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ABSTRACT

Fourth in a series of Child and Family Resource Program (CFRP) evaluation reports, this document is devoted to the program study component, designed to illustrate CFRP operations across the country and to establish a descriptive context for statistical and analytic findings. Chapter 1 describes the process of building a network of linkages with community agencies as experienced by the various CFRP's, discusses the current status of CFRP/agency relationships, and details the impact CFRP has had on access to community services for non-CFRP as well as CFRP families. Chapter 2 provides information about CFRP as a family-oriented child development program, examining staff views about family development, goals CFRP's attempt to accomplish with families, and reasons programs are successful with some families and not others. This chapter also describes the processes by which the needs of the individual family are assessed, family action is established, and family goals are ordered concluding with discussion of CFRP endeavors to deal with special problems and needs of various kinds of families. A descriptive profile of the three major components of CFRP (infant/toddler, Head Start, and preschool/school linkage) is presented in chapter 3, and anecdotal "success stories" concerning the impact CFRP has had on six families and their children are recorded in chapter 4. Finally, chapter 5 summarizes findings reported in earlier chapters and identifies program models currently in operation at the 11 CFRP's. (MP)

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EVALUATION OF THE CHILD AND FAMILY RESOURCE PROGRAM (CFRP)

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Phase III Program Study Report

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FOREWORD

In 1973, the Administration for Children, Youth and Families (ACYF) initiated the Child and Family Resource Program (CFRP) as part of the Head Start Improvement and Innovation planning effort. CFRP was funded as a demonstration program with the intent of developing models for providing services to low-income families with young children--models which could be adapted by different communities serving different populations. There are eleven CFR programs across the country, one in each of the ten HHS (formerly HEW) regions and one representing the Indian and Migrant Diviision. Each program receives approximately $155,000-$170,000 per year to serve a minimum of 80 families.

CFRP is a family-oriented child development program which provides support services crucial for the sustained healthy growth and development of families who have children from the prenatal period through age eight. It promotes child development and meets children's needs by working through the family as a unit and provides continuity in serving children during the major stages of their early development. CFRP services are offered within the context of three major program components--infant-toddler, Head Start, and preschool-school linkage. Each is intended to serve families with children in a specific age group; all three taken together are intended to provide continuity--especially developmental and educational continuity--across the period of a child's life from birth to the primary grades in school.

Another distinctive feature of CFRP is its emphasis on a comprehensive assessment of each family's strengths and needs and the development with the family of an individualized plan for services to be obtained through CFRP. Families enrolled in CFRP receive the same comprehensive services that are offered by Head Start and additional services tailored to the needs of each family. At the same time, CFRP works to reduce fragmentation and gaps in the delivery of services by existing community programs and agencies.

The CFRP Evaluation

In October 1977, the Administration for Children, Youth and Families funded a longitudinal evaluation to determine the effectiveness of the Child and Family Resource Program. The evaluation is designed to address three major policy questions:

- What is the nature and extent of services that should be provided to families and children in order to meet their needs, enhance their strengths and foster independence?
- What are effective processes for the provision of these services?
- What can be learned about the developmental processes of families and how they relate to the developmental processes of children?

The current evaluation was preceded by two other studies of the program, both also funded by ACYF. The first, conducted by Huron Institute in 1974-75, was an effort to determine the feasibility of a summative evaluation of CFRP. A formative evaluation of CFRP was also undertaken in 1974-75, by Development Associates Inc.; a follow-up study was conducted by the same contractor in 1975-77.

The initial design for the current evaluation consisted of three distinct but interrelated components which address the following objectives:

(a) description of CFRPs and their operations;
(b) identification of program models;

(c) linking of family outcomes to particular aspects of CFRP treatment (characteristics of staff and program) and to family characteristics; and

(d) linking of family outcomes to participation or nonparticipation in CFRP.

These objectives are addressed in three evaluation components--a program study, an impact study, and a process/treatment study--which represent complementary ways of viewing the effects and effectiveness of CFRP. A fourth component--an ethnographic study--was added to the evaluation in Phase III to broaden our understanding of how CFRP works with families and functions as a child development and family support program.

This is the fourth in a series of CFRP evaluation reports. The first report (February 1979) presented the overall study design. Study implementation and the collection of baseline data on evaluation families were the focus of the second report (February 1979). The third report (February 1980) consisted of three volumes: Volume I documented the first six months of the study and examined initial program impact on families; descriptive information about CFRP operations at the six evaluation sites was presented in Volume II; the third volume was a summary of the findings presented in the first two. The present report is devoted to the program study component of the CFRP evaluation.

The CFRP Program Study

The program study was designed to address the first two evaluation objectives listed above. The primary purpose of the study is to develop the broadest, most comprehensive picture possible of the operations of CFR programs across the country. It is intended that this picture function as a backdrop against which the provision of CFRP services to the individual family can be more clearly portrayed, and as a framework within which the impact of those services upon family and child can be understood. In addition, the program study is intended to identify and develop CFRP models that could be adapted or replicated in other communities.

The task of the program study is essentially a descriptive one. It relies heavily on impressionistic reports constructed from interviews with CFRP staff and observations during three site visits to each of the six sites selected for inclusion in the impact and process/treatment studies: Jackson, MI; Las Vegas, NV; New Haven, CT; Oklahoma City, OK; St. Petersburg, FL; and Salem, OR. These site visits took place in fall 1978, spring 1979, and spring 1980. Brief interviews also were conducted with staff from the five sites not included in the impact study--Bismarck, ND; Gering, NE; Modesto, CA; Poughkeepsie, NY; and Schuylkill Haven, PA--who attended the spring 1980 CFRP conference in Washington, D.C.

The first two site visits focused on the nature of the community and institutional contexts within which the six CFRPs operate; the way in which each CFRP is organized; the process by which client families are recruited, assessed, enrolled, and terminated; opportunities for parent involvement in CFRP operations; the nature and extent of services provided and referrals made; and the ongoing functioning of the program components--infant-toddler, Head Start, and preschool-school linkage. The findings were presented in Volume II of the Phase II Report (February 1980).

The current volume is organized around topics that were the focus of spring 1980 site visits and interviews with staff from the non-impact study programs. Chapter 1 describes networks of CFRP linkages with community agencies, and the process by which such linkages are established and maintained. It surveys the current status of CFRP/agency relationships and examines the impact CFRP has had on access to community services, for non-CFRP families as well as CFRP families. To obtain material for this chapter, interviews were conducted with representatives from different types of community agencies as well as with appropriate CFRP staff at the six impact study sites. (These topics were addressed to a more limited extent in interviews with non-impact study program staff.)

Chapter 2 provides information about CFRP as a "family-oriented child development" program. It examines staff views about family development, what CFRPs attempt to accomplish with families, and why programs are successful with some families and not with others. It describes the processes by which the needs of individual families are assessed, family action plans are established, goals are prioritized, and services are provided to CFRP families directly or by way of referral. In addition, it discusses special problems and needs of various kinds of families, and special ways in which CFRP endeavors to help solve those problems and meet those needs.

The three major program components of CFRP--infant-toddler, Head Start, and preschool-school linkage--are the focus of Chapter 3. The profiles presented here provide information concerning service delivery mechanisms used in each component, the focus of program activities, use of curriculum, and family participation in various aspects of the program. In addition to staff interviews, informal observations of infant-toddler activities were conducted at the six impact study sites. The ongoing record-keeping system on impact study families, all of whom are enrolled in the infant-toddler component, was used to examine levels of family participation.

Anecdotal data concerning the impact CFRP has on families and children who are enrolled in the program are reported in Chapter 4. They are presented in the form of six "success stories," one for each of the six impact study programs. Program staff were responsible for nominating one CFRP family that had obtained maximum benefits from the program. Extensive interviews were conducted with program staff to obtain information about the family's background, their circumstances when they entered the program, how the program worked with the family to help meet its needs, and finally the family's "success." Parents were also interviewed to get their side of the story.

Chapter 5 summarizes the findings reported in earlier chapters and identifies program models that are currently in operation at the eleven CFRPs. This chapter also examines and discusses the implications of these findings.

Acknowledgments

This report could not have been completed without the cooperation and assistance of numerous persons and groups. Several of these deserve special recognition for their contributions to this report and the evaluation effort.

We are especially grateful to Dr. Esther Kresh, the ACYF Project Officer for this evaluation, for her continuing guidance, assistance, and support. We also want to express our thanks to Martella Pollard, Director of the

CFRP Demonstration, and to Ray Collins, Chief of the Development and Planning Division at ACYF, for their interest and enthusiasm.

We wish to acknowledge the valuable assistance directors and staff at the six impact study sites have provided in the evaluation effort. They were especially helpful in arranging schedules for spring site visits and setting up appointments with various community agencies. We also wish to thank the directors at the five non-impact study sites for providing us with an opportunity to learn about their programs.

The six families selected for the success stories deserve special recognition. By agreeing to be interviewed by our staff, they provided invaluable insights into what it has meant to them to participate in CFRP.

We also wish to thank the National Advisory Panel for their guidance and assistance--Drs. Walter Allen, Tony Bryk, Jessica Daniel, Frank DiVesta, and Luis Laosa. In addition, we were fortunate to have Dr. (Ruth) Ann O'Keefe, former director of the CFRP Demonstration, as an ad hoc member of our panel.

Finally, we would like to acknowledge the work of Abt Associates Inc. staff and consultants who played major roles in the preparation of this report. Special thanks go to Lynell Johnson, who skillfully directed all aspects of the program study, including development of instruments, data collection, and report writing. Kathryn Hewett, a consultant to the project, had responsibility for the preparation of the success stories and collected program study data at one site. Other project staff who assisted in data collection include Dennis Affholter, Lorie Brush, Lucy Algere-Knox, Ilona Ferraro, Roz Ladner, and Jan Stepto-Millett.

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Project Director

Chapter 1

CFRP/COMMUNITY CONNECTIONS

The eleven CFRPs operate in a variety of community settings, ranging from highly urban to truly rural. The three classifications of urban, rural, and mixed (Table 1-1) are by no means adequate to reflect the variations. For example, the two clearly urban settings--New Haven (population 128,000) and St. Petersburg (236,000)--differ in a number of ways; among other things, whereas the New Haven CFRP serves low-income families in several areas of the city, the client population of the St. Petersburg program is concentrated in one area, where the program facilities are also located. The mixed urban/rural settings are also widely varied. In each case, the CFRP serves one or more urban centers as well as one or more rural areas or smaller towns. In the case of Poughkeepsie, Bismarck, and Jackson, this means a city of roughly 30,000 to 40,000 population

Table 1-1

CFRP Communities

	Urban	Rural	Mixed
Bismarck			x
Gering		x	
Jackson			x
Las Vegas			x
Modesto		x	
New Haven	x		
Oklahoma City			x
Poughkeepsie			x
St. Petersburg	x		
Salem			x
Schuylkill Haven			x

plus the surrounding rural district. Schuylkill Haven is a similar case, except that the largest city served--Pottsville--is somewhat smaller (18,000). Each of the other "mixed" settings involves a major city and a smaller town: Oklahoma City (378,000) and rural Spencer (3,700); Las Vegas (133,000) and suburban Henderson (19,500); Salem (73,000) and nearby Dallas (6,400). Finally, the Gering and Modesto CFRPs both serve predominantly agricultural counties. However, the facilities of the former program are located in Gering itself (population 6,700), whereas the Modesto facilities are located at the rural housing projects where the families of farm workers served by the program reside.

With a few exceptions, CFRP staff at all sites believe that the resources afforded by these communities to low-income families are adequate to meet those families' needs. The exceptions include a lack of facilities for recreation and adult education in Spencer, Oklahoma; unavailability of dental care in St. Petersburg; unavailability of medical and dental care in Gering; a lack of psychological services in Schuylkill Haven; and inadequate medical and mental health services in Poughkeepsie. Even at the remaining sites, however, the fact that resources and facilities are present does not always mean that they are readily accessible to CFRP-eligible families. Some of the obstacles to access are peculiar to certain sites: for example, in Modesto and at other sites where a large proportion of CFRP client families are Hispanic, language represents a major barrier. The obstacles that are most common across sites are lack of adequate transportation facilities to get families to agencies, and lack of information on the part of families as to what resources are available. One CFRP coordinator suggested that CFRP actually stands for "Can't Find Resources Properly."

Improving access to community services for client families is an important part of the CFRP mandate, and is the theme of this chapter. Section 1.1 describes the process of building a network of linkages with community agencies, as experienced by the various CFRPs. Section 1.2 discusses the current status of CFRP/agency relationships. Section 1.3 details the impact that CFRP has had on access to community services, for non-CFRP families as well as CFRP families.

1.1 Network Development

For the local CFRP to fulfill its mandate to reduce the fragmentation of community services for client families, to give them one place where they can turn for help with a variety of problems, the program must establish and maintain a network of linkages with agencies that provide a variety of such services. All eleven CFRPs were established at sites where Head Start programs were already in place and had at least some linkages with community agencies. This meant that each of the CFRPs had a base from which to work in beginning to coordinate community services. At nearly every site, however, the Head Start network needed to be expanded and/or changed.

The kind of change required took a number of different forms. In St. Petersburg, for example, the network was already fairly comprehensive and was working well, so the coming of CFRP simply meant the addition of one or two more agencies. In Las Vegas, on the other hand, Head Start had few linkages and was paying for most family services. The institution of CFRP crystallized the need to make connections with new agencies, but also to interact with agency personnel in different ways. Whereas Head Start had tended to assume the role of an antagonist, CFRP staff approached agencies more positively, assuming they wanted to help. At a number of sites, relationships with agencies became more formal--often involving written agreements--and more permanent; whereas under Head Start it was often the case that the appropriate agency would simply be contacted for help as the need arose, under CFRP personal contact was regularly maintained. More follow-up work on individual cases also began to be done.

In general, most community agencies were receptive toward CFRP efforts to establish connections. They welcomed the "total family" orientation of CFRP, and recognized the need for a program that would ensure that families did not "fall in the cracks" between the jurisdictions and mandates of more specialized agencies. At a number of sites, most notably St. Petersburg, agency personnel provided enthusiastic support and input during the process of developing the original CFRP proposal and establishing the program.

There were some concerns, however, including fears that CFRP would duplicate the services of existing agencies--characterized by CFRP staff as a concern for "turf protection." At a number of sites, program staff had to give frequent assurances that their intention was not to duplicate services that were already being offered, but to form a supportive network to ensure families' access to those services. In fact, the director of the Oklahoma City program indicated that CFRP staff at that site initially saw themselves as offering a cure-all--*replacing* rather than *linking*. They had to learn to respect the expertise and prerogatives of agency personnel, to modify their goals and take on more of a coordinating role, "identifying gaps and plugging them." Some agency people also tended to look askance at CFRP staff because of their paraprofessional status. They were doubtful of the program's ability to handle certain kinds of family problems, and also of the staff's judgment on when to refer a case to "experts." Others feared that CFRP would try to tell them how to run their program. As described by one CFRP director, this really meant that the agency was being asked to do something different or special, and agency personnel were inflexible, wanted to maintain the status quo, were "not interested in humanizing services." Most such concerns have been laid to rest as CFRP/agency relationships have developed and improved over time. Nevertheless, at sites where CFRP began with a strong network of community linkages and the CFRP initiative evoked early positive agency support--as in St. Petersburg--the maintenance of these relationships has been comparatively easy. At some other sites the building of the network has been a continuing process which has required considerable effort and attention and has at times been problematic.

The process of building a network of community linkages may be simply described as one of people meeting people. The theme of personal contact runs throughout all of the descriptions. At most sites, this involved many meetings over a long period, often to discuss individual families--the interest which personnel from nearly all agencies have in common. Over time, this has typically become a system of "interlocking directorates," with CFRP staff sitting on boards and committees of other agencies, agency staff sitting on CFRP and Head Start boards and committees, and both sitting on interagency councils.

CFRP staff at several sites were asked what advice they would give someone who was starting a CFRP in a new community, in terms of agency linkages. The following points recurred in their responses:

- Know the power structure of the local community. Enlist the involvement of politicians, business leaders, and community activists. Make sure they understand the program and its intentions and goals, and get commitments of support from them.

- Establish connections with community agencies early, before any clients show up, and get commitments from them. Where possible, make connections with an assortment of agencies that offer a given service, so that there are options. Agencies differ (for example, in how rigidly they apply their rules), and the agency/family "match" is important. Make personal contact--and maintain regular contact--with key agency personnel, the people who make decisions, but do not limit your relationships to them. Make friends and allies at all levels.

- Learn in detail about every agency you think families are likely to use. Observe a lot, but do not "snoop" too much. Do research in terms of the agency mandate; know what is possible, what the rules are. Develop some good arguments as to why the agency should serve your clientele. Proceed on the assumption that the agency wants to do good things for families. Do not be intimidated. Argue issues, even when the problem is one of personality.

- Make sure agency personnel understand your objectives, that your purpose is to work together with them in a complementary fashion to accomplish things for families. Work to develop trust, to assure agency people that you are not in competition with them. Talk about what you can do for them. Give something first: people get tired of being asked for things. On the other hand, CFRP can sound like "the answer to everything." Avoid implanting unrealistic expectations.

- Hire good people who represent the feelings of the client population but who are also sensitive to the perspective of agency personnel. They must be professional enough to deal with professionals. They must also be flexible, and should be allowed the leeway to work out relationships in their own ways.

- Where possible, get your own people "planted" in other agencies--in staff or consultant capacities, on boards or committees, or in whatever way you can. (At one site, one CFRP staff member's husband is a local judge, another a lawyer. At another site, the husbands of two staff members are ministers in influential churches. Staff use such connections, when necessary, to help families.)

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- Be patient. New programs must prove themselves, and it takes time to develop a relationship.

1.2 CFRP/Agency Relationships

Within each CFRP, a social services coordinator or another member of the administrative staff has overall responsibility for the establishment and maintenance of linkages with community agencies. On a day-to-day level, however, these relationships are in fact maintained by family workers, who handle most referrals--and in many cases take families to agencies. The type of agency worked with most closely varies from site to site, and this does not appear to be connected with variation in family needs from site to site. Rather, a prime determinant appears to be personal compatibility between key people at the agency and in CFRP--or, more simply, a willingness to cooperate on the part of agency personnel. In general, most CFRP/agency connections are viewed as good working relationships, by both CFRP and agency staff. At several sites, CFRP staff had difficulty identifying an agency where they had been unsuccessful in establishing an effective connection. However, even "good" relationships may vary considerably: that is, some good relationships are better than others.

The most obvious benefits of such positive CFRP/agency relationships are to families: even though nearly all agencies serve non-CFRP families as well as CFRP families, the latter are likely to enjoy improved access to agency services. In Las Vegas, for example, staff at the public dental clinic go out of their way to accommodate the schedules of home visitors, who bring in several CFRP [illegible] at one time for treatment. In Oklahoma City, the [illegible] relationship between CFRP and the Mary Mahoney clinic ensures that client families will receive high-quality comprehensive health care.

Close CFRP/agency relationships also facilitate the work of CFRP. In one case in Oklahoma City, a CFRP mother brought her child to the Mary Mahoney clinic covered with what appeared to be cigarette burns; she apparently believed that someone at CFRP had abused the child. Clinic staff called CFRP, but also examined and treated the child. The case was finally diagnosed as impetigo, and the mother returned to the program. If the clinic had overreacted in this case, it could have had severe negative consequences for the program--without helping the mother and child. Similarly, in Jackson CFRP staff identified a case of child abuse; because of their linkage network, it was possible to have the case officially reported by another agency so CFRP could maintain a relationship of trust and continue to help the family. Another way in which local CFRPs are aided by their relationships with community agencies is in the provision of training and education of CFRP staff and parents by agency specialists. On the other hand, CFRPs also often lend similar aid in the opposite direction. Further, as already noted, personnel from CFRP and a variety of other agencies frequently meet to discuss individual cases of families in need, and serve together on boards and committees.

When relations between CFRP and a given community agency are poor, it is families that suffer--although CFRP staff may experience severe frustration. The primary causes of poor relationships are: (1) personality clashes and misunderstandings; (2) inflexibility of agency procedures and red tape; (3) an inability or unwillingness on the part of agency personnel to serve low-income or minority clients; and/or (4) a negative opinion of CFRP on the part of agency personnel. At one site, a local health center contracted with the CFRP to provide health screening, immunization, and follow-up treatment for client families. The relationship has been marked by constant animosities, and by serious disagreement as to the terms of the contract. At another site, the welfare and housing agencies are seen as inflexible and bureaucratic--although individual workers may be quite helpful. In one case, a mother was walking the streets with her children, with no place to go. CFRP called the housing agency, and they said they had no facilities for emergency housing; they offered no help, and suggested no alternatives. Finally the local manager at a housing project let the family in. When personnel at this housing agency were interviewed by Abt Associates research staff, they claimed they had never heard of CFRP--yet one of those interviewed was involved in a family lawsuit where CFRP was also involved.

At some agencies, personnel are simply recalcitrant or unconcerned in regard to the needs of low-income families. When one CFRP director suggested a meeting with the city welfare director to discuss augmenting services to families, he said he was not interested, that his agency's role was "to give them the check." Agencies which are set up to serve all comers with an identified need--which have no income guidelines--tend to be particularly unhelpful. At one site, a public health agency that serves handicapped children has had a history of taking only middle- and upper-class families. The CFRP director challenged the agency's leadership on this issue and--after a long and acrimonious dispute--won some slots in the agency's client roster for CFRP children. However, the agency has continued to resist providing care to low-income and minority children, and every instance of such care represents a hard-fought battle. Interestingly, there is a key staff person in this agency who is sympathetic to CFRP and works closely with program staff--but in doing so she goes against the wishes and directives of her superiors in the agency. At another site, a family counseling agency was described by CFRP staff as being geared to middle- and upper-income families. Agency personnel are said to be unable to communicate effectively with a low-income population, especially blacks. Staff at the agency indicated that about one-third of their clientele are low-income, but they do have problems serving these families: they must be picked up; they frequently cancel appointments; they lack motivation, because they often did not initiate the therapy process and they are not paying for it (fees are on a sliding scale). Personnel at this agency said that they welcome CFRP referrals, but do not have room for many of these families; they also expressed some doubt as to whether CFRP staff--not being professional--really know when a family should be referred.

Very few agency personnel interviewed at any site expressed a negative view of CFRP. In one case, a public health official did indicate a continuing concern over duplication of services; specifically, she said that CFRP staff should be more open to making referrals to medical practitioners rather than trying to deal with problems themselves. A case was cited of a woman who showed signs of depression before the birth of her child; after the birth, she went into a very serious depression, and CFRP staff then made a referral. The referral should have been made earlier, in the opinion of this official. This person also said that more intensive treatment over a shorter period of time (as practiced by the public health department) might be more effective and foster less family dependence than CFRP's more long-term approach. Nevertheless, she went on to say that the CFRP emphasis on continuity is a good one, and that program staff obviously care about children and parents and do them some good.

In general, agency views of CFRP are very positive. Sometimes this is based on a rather narrow perspective: one agency official said that CFRP is good because it makes sure that children get good dental care--the services his agency provides. However, most agency personnel are aware of what CFRP does, and they like it. An agency staff member said of Las Vegas: "This is a 24-hour town, a large city, functioning like a cow town." She went on to say that the community is seriously deficient in delivery of services to the poor, and that without CFRP people would have nowhere to go. In Oklahoma City, CFRP was referred to as "an ombudsman for people who don't have a voice," as a program that takes advantage of available resources in the community and in turn makes them available to families. A number of agency staff members in St. Petersburg expressed the view that CFRP has put a previously excluded segment of the population in touch with needed family services. One agency representative at that site said, "Gosh, I like what they're doing!" She said that CFRP "works just as effectively as you could possibly imagine," given its funding. In Salem, an agency staff member praised CFRP's comprehensive approach, the fact that the program deals with both children and parents; she said that CFRP can do "remarkable things" with multi-problem families. She said she wishes the program could take more families: "I can think of families I'd love to get in there right now."

This was by far the most common response of agency personnel to a question as to how CFRP might be improved: increase its funding and its coverage. A number of these agencies refer families to CFRP, and some personnel are frustrated by CFRP's inability to take more of these families. In one case, it was suggested that this is not only because of lack of room, but that there are other obstacles as well. An agency representative indicated that CFRP does not respond quickly enough as to whether there will be a place in the program for a given family. She also said that CFRP is not accepting enough of crisis situations, and is inflexible about the type of parents the program will accept. She cited a case in which a mother was blind, and could not come to the center more than once a week. The

CFRP said that was not enough participation, and refused the family admission. It should be noted, however, that this negative view is the exception rather than the rule, and that most agency staff cited only funding limitations and income guidelines as obstacles to referral.

There are some special cases of referrals to CFRP, where a court or a government agency will insist on a family's involvement in the program. At several sites, there have been cases where a mother whose children were in foster care was allowed to regain custody only if she stayed in CFRP. In one case in Jackson, involving a custody fight between a teenage mother and the grandmother, the school asked CFRP to intervene on behalf of the mother. The director of the Las Vegas program said that a number of teenage mothers have been referred to CFRP by the juvenile court, but that the court does not follow up on this; on the other hand, in many cases the court experience itself is frightening enough to the mother so that she "gets her act together." A representative of family court services in Salem said that she frequently makes referrals to CFRP, expecially in custody cases, and that the program is an important source of information and help. Special referrals of this kind, especially in crisis situations, bear eloquent testimony to the high esteem in which CFRPs are held by court and agency staffs--and also to the importance of close CFRP/agency relationships.

1.3 CFRP Community Impact

"I have not seen one service requested by a family that we could not find for them," said one CFRP supervisor. Perhaps not every local CFRP has been quite that successful, but all appear to be doing an effective job of making sure that client families receive the services they need. In the process, they have sometimes had a broader impact, and have influenced the availability of services to non-CFRP families as well.

At several sites, at the time CFRP was instituted there were a number of family needs within the low-income population for which virtually no resources were available. CFRP set out to change that situation. In Bismarck, for example, program staff helped set up a Community Pantry for emergency aid, with the resources coming from private institutions; CFRP also provided office space so that WIC could be established locally. In Gering, CFRP initiated the development of a well-child clinic with the help of a number of cosponsors. In Oklahoma City, when a group of churches set up an agency to provide materials and labor to help low-income families with home repair, CFRP worked closely with them in identifying needs and facilitating their program. At many sites CFRP has been instrumental in setting up interagency councils to increase communication and cooperation among agencies. Such actions have improved access to community services for all low-income families, not for CFRP families alone. On the other hand, where services have simply not been available--and no one else is willing to offer them--CFRP has gone into the business of providing services directly to its client families. The most obvious example of this is transportation to other agencies, but local CFRPs also directly provide health screening, counseling, day care, and even translating services--either because these are not available elsewhere or because their availability is in some way hampered by inadequate resources, agency attitudes, or other access problems. In Schuylkill Haven, when CFRP began there were no infant day care services available. The program set up an infant day care center under its own umbrella.

The impact of such direct services is typically limited to CFRP families. A prime example of this kind of impact is the situation with dental care in Las Vegas. Staff at the public dental clinic testified to the fact that CFRP children get better dental care than children from non-CFRP low-income families precisely because home visitors bring the children to the clinic. The treatment record for one boy constituted graphic evidence of this effect. For a period of months, the family was enrolled in CFRP and the boy was receiving regular care. Then the mother dropped out of the program, and for the ensuing months the treatment record is a list of broken or missed appointments; finally the clinic staff told the mother they would make no more appointments for her son, even though he was eligible for treatment, since the appointments would apparently not be kept--but that if she rejoined CFRP they would be happy to treat the boy. She later did enroll in the program again, and from that point on the boy received regular treatment.

The access to services of CFRP families is also enhanced by the program's advocacy efforts with other agencies. In some cases, families get services only if agency personnel are "pushed" by CFRP staff. Agency personnel are often simply more willing to listen to CFRP staff than to parents. In Salem, program staff have been successful in persuading an agency which enforces child support rulings not to take certain families to court; in one case a father was kept out of prison due to the intercession of a family advocate. CFRP may also be influential in changing the ways in which agencies work with families. A representative of family court services in Salem said that she is likely to continue working with a CFRP family rather than sending them on to a more prescriptive agency because CFRP is available as a resource.

In some cases the changes in agencies wrought partially by CFRP advocacy may generalize to non-CFRP families as well. In New Haven, for example, CFRP staff influenced the staff of a local health center to adopt more of a family orientation in their work, to expand their facilities for mental health and prenatal services, to change their hours, and to improve the ethnic match between staff and families. In Salem, CFRP staff were instrumental in getting one agency staff member fired, and in persuading the agency to take a less rigid and punitive attitude toward families. In Modesto, CFRP staff did an effective job of providing a "cultural education" to public health personnel, making them more sensitive to the perspectives of Mexican families--and better able to work with them. At many sites, CFRP staff feel that staff at other agencies have become less intolerant of low-income clients because of their interactions with the program. In a more indirect way, CFRP has served as a model for broadening of services; in many cases program staff have been asked to train agency personnel in family advocacy and service provision.

Ultimately, however, CFRP staff are concerned with the program's impact on *CFRP* families. Further, they are not content merely to advocate for families. As the coordinator of the Schuylkill Haven program put it, in the case of a repressive agency, "We give parents the information, and *they* fight back." When asked about CFRP's most important accomplishments in terms of reducing fragmentation, increasing access, and improving the quality of social services in the community, one program director mentioned families' awareness of themselves as competent and able to get access to services on their own. Another said: "Getting families to feel they're part of a community, that they can go to an agency--they have a right, the agency is there for them." As an important afterthought, she added, " . . . also, that CFRP will stand behind them."

Chapter 2

CFRP SERVICES

The Child and Family Resource Program is a "family-oriented child development" program. Its ultimate objective is the optimal development of children, but it approaches this objective by offering help and support for the development of families. What this means in both philosophical and practical terms is the theme of this chapter. Section 2.1 deals with the view of family development held by staff at the eleven CFRPs, and what they attempt to accomplish with families--in particular, their emphasis on coping and independence--and why the programs are successful with some families and not with others. Section 2.2 describes the processes by which the needs of the individual family are assessed, the family action plan is established, and family goals are prioritized. Section 2.3 deals with the focus of home visits and the services provided to CFRP families directly or by way of referral. Section 2.4 discusses the special problems and needs of various types and categories of families, and the special ways in which CFRP endeavors to help solve those problems and meet those needs.

2.1 The CFRP Approach

In general, CFRP staff see support of family development as a major function of the program because family development leads to--or at least is a prerequisite for--child development. Many statements are made about capitalizing on family strengths, helping families "feel good about themselves," and improving the quality of family life, but these are within the child-development context. Thus: "The home is a factory making people." The goal of one CFRP is stated as follows: "To assist each family in developing its fullest potential as an effective child-rearing system and to assist each child in realizing his/her individual potential."

In practical application, this philosophy of family development and its connections to child development has several interpretations (which are not mutually exclusive):

(1) Clearly, the program is concerned with parents' understanding of child development and their ability to interact effectively with their children, to handle matters of discipline, to deal with school personnel, and so on. (The parent education aspect of CFRP is addressed more directly in Chapter 3, which discusses program components.)

(2) Conditions of need may inhibit parenting skills by distracting parents, preventing them from "attending to child development," as one CFRP coordinator put it. It may sometimes be necessary for the program to intervene and assist in meeting basic needs before the parenting issue can be addressed.

(3) Quite aside from parenting skills *per se*, in the extreme case where a parent is grossly incapable of coping with the basic needs of the family and the child, the child's physical, emotional, and intellectual health and development are in immediate jeopardy; to the extent that the parent *can* cope, the home environment is conducive to the child's health and development. Again, the program may intervene directly to help in meeting needs, but only until the parent is able to take over responsibility for doing so. Certainly CFRP staff will work at providing help and support to the parent in learning to cope more effectively.

(4) If the parent is unable to cope, the child may also fail to cope, as a result of imitating the parental model. If parents can be helped in learning to cope more

effectively, their children will also learn--and thus will also be helped.

One CFRP director pointed out that it is easy to fall into a habit of viewing families in terms of their problems, rather than asking the more positive question: What is good about this family? The CFRP approach is based on the assumption that some things are good about every family. All families change and develop, but each must do so in its own way. The program should "mirror what families want," and provide information, support, encouragement, and enrichment to the development process for each family individually. Ultimately, the family is and must remain the "responsible party."

Stages of Family Development

Not surprisingly, CFRP staff typically describe stages of family development in terms of two closely related concepts: coping and independence. It is possible to identify three such stages. It should be noted that these stages are not viewed as constituting an invariant sequence through which all CFRP families pass. A family might conceivably be in any one of the three stages at the time of program entry. Further, a family that is in one stage might at times display attributes that are characteristic of another. Nevertheless, the stages do represent a continuum, and provide a useful way of looking at family development.

(1) The non-coping family is at the mercy of their environment, either because they do not realize they have a problem that needs to be dealt with or because they cannot deal with a problem they do know about. Such a family is usually lacking an adequate support system and has little knowledge of available resources which might be brought to bear on its problem. In relationship to CFRP, such a

family is highly dependent, expecting the program to "do" for them rather than to help them "do" for themselves.

(2) In the intermediate stage, the family is beginning to be aware of options and alternatives and of its own potential strengths, and to make choices. Where CFRP is concerned, this is the beginning of separation--and even, sometimes, of rebelliousness on the part of the family.

(3) The coping family sets goals and plans and works toward them. They are in the process of forming their own support system. They are relatively independent of CFRP, but are able to contribute to the program and even to offer help to other families.

CFRP staff agree that the outcome domains of parent-child interaction and child development are central to the overall objectives of CFRP and that, over time, all families who participate actively in the program should be expected to benefit in these two areas. It should be noted, however, that some CFRP staff pointed out the difficulty of measuring benefits in the area of child development and therefore prefer to emphasize parent-child interaction. Beyond this, it was mentioned that involvement in the program should result in changes in the home environment--that it should become "more of a learning environment." One CFRP director said one outcome should be that parents "feel good about being adults and about raising children, that it's important and worthwhile." In this connection, many staff used such terms as "pride in parenthood," "self-image," "self-concept," "self-esteem," and "self-confidence." Once again, coping was a central theme. Staff talked about "courage to live in the world," facing the reality that "nobody's happy all the time," acting "not because of things all the time, but sometimes in spite of them," being more goal-oriented and less crisis-oriented. One CFRP coordinator said: "Coping is the ultimate goal--to be an independent, selffulfilling unit that would not need CFRP services to be able to cope."

Predictors of Success

The various CFRPs are much more successful with some families than with others in accomplishing program goals. Some families are not all that far from "success" when they enter the program; they just need a little added "push" of encouragement, "the opportunity to do well." (In this connection, the director of the Gering program mentioned that they are most successful with Mexican-American families, who are usually just lacking information.) Such families can often be identified readily and quickly move on to success--and relative independence.

Other families are not nearly so strong at the time of entry into the program. The crucial question for these families is one of motivation--whether they are willing to change and to invest time and energy in program participation to gain its benefits. The following characteristics are among those listed as typical of potential "successes":

- They see a need for change.
- They see something in CFRP that matches their need.
- They ask a lot of questions, and are open in sharing information about themselves.
- They show up for appointments and follow through on referrals.
- They participate actively in home visits and center sessions.
- They are persistent, and do not give up easily if what they want does not happen immediately.

CFRP staff reported that they are not likely to be successful with parents who want to "use" the program, to get CFRP to do for them what they should be doing for themselves. One director suggested that this may be a problem especially with families who have been on welfare, for whom government assistance has become "a way of life." Further, the chances for success are greater with families who come to the program because they feel it has something to offer than with families who are referred because some other agency could not help them. Clearly, family _expectations_ of success are an important factor.

In addition to family characteristics that are predictive of success, there are certain program and staff characteristics which also play a role. A match between program services and family needs is essential. A match between CFRP family worker and family is equally important; if they "click," there is likely to be positive change. In more general terms, family workers must be highly sensitive; they need to watch for "approachable moments," to "listen to what parents are saying about themselves." Family workers also must be very patient; it may take a year or more for rapport to be established and for genuine progress to begin to appear. One CFRP director described angry, resistant, volatile parents that insist on staying in the program, "testing" the program because they really need help. Sometimes even such families "succeed." Finally, as with family expectations, staff expectations are crucial: if the family worker expects success with a family, success is considerably more likely.

In general, CFRP staff feel that they are doing a very effective job in serving their client families. They cite three major reasons for their effectiveness:

(1) _Support_. Families need a support system--a place to turn. CFRP offers a nurturing, supportive environment, and also helps families develop their own support systems.

(2) Comprehensiveness. When families go to a single-service agency for help, if they are not eligible for that agency's service or if the agency does not offer the service they need they receive no help. CFRP "puts the plug in the bathtub, brings all the services together." If CFRP does not offer a given service directly, it makes a referral and follows up to ensure that the service is obtained. Further, the program's family orientation means that the child is not viewed in isolation from the system and the people with the most direct influence on his/her life.

(3) Individualization. CFRP services are adapted to meet the specific needs of the specific family and child.

2.2 Needs Assessment

In order for the CFRP effectively to individualize its services to meet a family's needs, program staff must have detailed knowledge of those needs. The mechanism for obtaining that knowledge is the assessment process. The process begins with a family advocate or home visitor meeting with the family one to several times, usually over a period of four to six weeks. One purpose of these meetings, which are ordinarily held in the home, is to acquaint the parents with the benefits and options available within the program and to make clear what is expected of them as participants. Either at the beginning or end of this series of meetings, parents are typically expected to indicate in some formal way their commitment to the program, often by signing an agreement.

A second purpose of these initial meetings is pre-assessment. This involves the gathering of eligibility data as well as information on family needs. The latter information is passed on to an assessment team, which may include family advocates, home visitors, supervisory and support staff, and--when appropriate--staff members from other community agencies. This team is then brought together for a formal assessment meeting. Parents are generally encouraged to attend the meeting; in Bismarck, Gering, Las Vegas, and Salem their attendance is required. In most cases it is the mother who attends, as work schedules often preclude the father's presence. The assessment meeting is the basis for establishing specific family goals and determining who will take what steps, and when, to achieve those goals--the family action plan. Parents are expected to provide input during the goal-setting process, and the action plan is typically the product of mutual agreement between parents and CFRP staff. In fact, it is often the case that the assessment meeting simply involves the formalizing of a set of goals and steps toward those goals already agreed upon by the parents and the family worker. At this point, the family is considered enrolled and may begin to receive services.

Assessment is carried out in this manner (allowing for some site-to-site variation in timing and precise procedure) at ten of the eleven CFR programs. The exception is New Haven. There, once a family has provided initial enrollment and eligibility information, a home visitor makes contact to arrange a schedule for center sessions and home visits; it is not necessary for a family to have a home visit before attending center sessions. If the family has a number of social service needs as identified by the home visitor, a family advocate visits the family, sometimes accompanied by the home visitor, to begin the assessment. The family advocate then completes a family assessment form which contains a plan for providing services. This is done with parent input, but parents are not required to review the actual plan. If no immediate family problems are identified by the home visitor, the family advocate may simply introduce herself and her role at a center meeting, and not see the family until something is needed. There are no formal assessment meetings in New Haven.

Reassessment

Reassessment is scheduled periodically for each enrolled family. The interval varies from program to program, ranging from three to twelve months. However, in every program, crises or changes in family circumstances may precipitate a special reassessment, outside the regular schedule. Further, newer families may require reassessment more frequently than families who have been in the program for a year or more. The purpose of reassessment is to evaluate the family's progress--as well as the effectiveness of the program in meeting their needs. In some cases (Jackson, for example) CFRP staff report that reassessment is less involved and less time-consuming than initial assessment; in other cases (St. Petersburg) it is said to be more in-depth, because staff have more family data available to them. At some sites, such as Oklahoma City and St. Petersburg, the typical procedure for reassessment is for a number of families to be reviewed at weekly or monthly assessment meetings. Reassessment usually leads to a new family action plan, or to revision or extension of the existing plan. (The exception to this description, again, is New Haven, where reassessment is seen as an ongoing process and is not regularly scheduled; as situations change or new problems arise the family advocate may discuss these with other staff members, and new goals or plans may result.)

Prioritizing Goals

In general, CFRP staff view family needs in terms of goals to be met. A question of interest for purposes of the CFRP evaluation is how family goals are prioritized.

How is it decided which goals the family worker--and the family--will work on first and/or which goals will receive the most attention? There are actually two questions here: (1) Who sets the priorities? (2) What criteria are used?

First of all, it is clear that in most cases family goals are prioritized. Only very occasionally does a family worker insist that all of a family's goals are of equal importance and urgency. Secondly, the prioritizing process usually involves joint decision-making by the parents and the family worker. In many cases the family worker indicated that the parent makes the priority decision, yet--almost invariably--went on to reveal that the decision is typically not strictly unilateral: "I take what they think is Number 1, even if I disagree," one family worker said. She then discussed the procedure she follows if she considers a family goal to be unrealistic, in helping the parents to realize that and subtly directing them toward other goals. Another family worker described the mutual decision-making process more directly: "Usually the parent says what's important to them, then I point out what may occur to me." It appears that in some cases the balance may be tipped in the opposite direction: instead of the parent deciding, with input from the family worker, the family worker takes the initiative in making the decision with input from the parent. A family advocate pointed out that one factor to consider in assigning priorities is whether a specific goal is one the program can help with.

The question of who sets the priorities cannot be dissociated from the question of the criteria used. Some problems are so obvious, and even critical, that they are readily recognized as having priority: little negotiation between parent and family worker is required. For example, some family workers mentioned serious, life-threatening illness as taking priority over all other family needs, or indicated that the most pressing problem is addressed first. Others cast the decision-making process in the mold of a kind of Maslowian hierarchy of needs: "You can't do much on other goals until you have food and shelter." In this same connection, the attainment of one goal is often seen as a prerequisite to the pursuit of others: "To fulfill the other goals they need more money." "The real priority is a job, but child care is necessary before a job is possible."

The last comment points up the fact that priority is a dual concept, involving what is most important as well as what comes first. When there is a critical need, these two considerations coincide; when there is not, less important goals may be addressed first. One family worker described prioritization of goals this way: "I will go with what the parent thinks. If something can be finished in a short time, we might work on it first. If the parent wants or needs to get a bother out of the way, I give support for that. But I don't let long-term, more intangible goals get lost."

2.3 Service Provision

Each local CFRP is mandated to serve a minimum of 80 families. As shown in Table 2-1, the actual number enrolled ranges from 84 (Bismarck) to 220 (Jackson). The ethnic distribution of families served also varies considerably from site to site. The ethnic distribution of CFRP staff tends to be quite similar to that of families.

CFRP contact with client families takes two principal forms: center sessions and home visits. Center sessions tend to be education-oriented. In some cases they are directed toward the child, or toward the child and parent together; even when they are exclusively directed toward the parent, however, they tend to be concerned with educating the parent in child development, parenting techniques, or family management. Further, because they are group sessions, there is a limit on the degree to which they can be individualized to meet the needs of a particular family. (Center sessions are discussed in more detail in Chapter 3.)

Home visits, by contrast, can be individualized in the extreme. In addition, while home visits may be--and often are--concerned with child development and parent-child interaction, they also provide a context in which the needs of the family as a whole can be addressed and dealt with. In two programs, Jackson and New Haven, these two functions of the home visit are assigned to separate family workers (for families in the infant-toddler component, at least). That is, one family worker (a home parent teacher

Table 2-1

CFRP Families: Ethnic Background (percent)

	N	Black	White	Hispanic	Native American	Asian	Interracial/ Other
Bismarck	84	0	87	0	6	4	4
Gering	99	1	27	54	14	0	4
Jackson	220	33	66	<1	<1	<1	0
Las Vegas	97	58	16	24	2	0	0
Modesto	100	0	0	100	0	0	0
New Haven	85	79	7	13	0	0	1
Oklahoma City	103	91	5	1	1	0	2
Poughkeepsie	135	39	42	5	0	0	14
St. Petersburg	88	98	2	0	0	0	0
Salem	138	11	72	9	0	0	9
Schuylkill Haven	135	0	96	0	0	0	4
Overall	1284	35	44	16	2	<1	4

in Jackson, a home visitor in New Haven) conducts home visits that are focused on child development and parenting; another (a family life educator in Jackson, a family advocate in New Haven) conducts home visits that are focused on family needs in a more general sense. In these programs, the first type of visit tends to be more structured in advance than the second type. In Jackson, for example, the home parent teachers use the Portage guide as a basis for designing home visit activities appropriate to the development of the individual child; family life educators begin a visit by finding out how the family is doing, what has changed since the last visit, what kind of progress has been made on goals, and so on, then build the rest of the visit around the answers to these questions.

In the other nine programs, one CFRP worker plays both roles during home visits. There is considerable variation from program to program (and some, though much less, within programs) in the extent to which the agenda for a given home visit is typically "preset" by the family worker. As reported in the following chapter--in Section 3.1, on the infant-toddler component--some follow a curriculum, others follow a lesson plan developed or chosen to meet the needs of a particular child, and others do little or no prior planning of their visits. Without exception, however, some opportunity is provided during the visit for the parent to raise issues about which she is concerned, and the family worker endeavors to address them. Some of these concerns may revolve around the child; many do not, but rather have to do with housing, employment, adult education, and other family needs. Several family workers expressed the view that child development and parent-child interaction should be the focus of the visit, but if the family is having problems planned activities are set aside.

Direct Services and Referrals

What does the CFRP do to help? There is some variation from site to site in the mix of services provided directly and by way of referrals. The differences reflect the local situation with respect to availability of resources to meet family needs, as well as the particular strengths of the local CFRP. However, the similarities are stronger than the differences.

Obviously, every CFRP provides developmental services to children (including developmental assessments at most sites) and educational services to their parents. (It should be noted that among the educational services offered by the Modesto program is instruction in English; the language barrier is a significant one for this program's unique client population.) In addition, staff from nearly every program list counseling among the services they provide directly to parents. It appears that this counseling ranges from a sympathetic "listening ear" during home visits to professional clinical help. A number of family advocates and home visitors are trained counselors; further, several programs retain the services of mental health professionals who are made available to CFRP families.

The majority of the programs also offer health and nutrition screening and immunizations, and several offer various types of treatment, such as speech therapy or the services of a dental hygienist; these are often provided by people from outside the CFRP, who may be paid by the program or may donate their time and work. Other direct services mentioned include job counseling, legal advice, and recreation opportunities. In some cases services may not be provided at the program, but may be paid for by CFRP, such as emergency health care or food and clothing.

CFRP staff differ somewhat from site to site in the degree to which they prefer to provide services directly as opposed to referring families to other, more specialized agencies to receive services. When asked about the role of CFRP in increasing access to community services, one program supervisor said: "That's what we do." Certainly all CFRPs make referrals, putting families in contact with the agencies that can best meet their needs. (This work is generally done by family workers themselves, and coordinated by a social services specialist or the CFRP supervisor.) Referrals are most commonly made for medical diagnosis and treatment, counseling and mental health services, welfare, education, job training, employment, emergency food and clothing, and emergency fuel allotments and weatherization. However, where family needs are concerned, some program staff--as in Las Vegas--see themselves as being primarily in the business of providing a connection between client families and a network of community agencies which offer needed services. Others--as in Salem--see themselves as being primarily service-providers, in a direct sense. The Las Vegas CFRP hires no outside people to offer specialized services within the program, but rather sends families "outside" to get such services. The Salem CFRP frequently hires outside personnel to offer specialized services because of its preference for direct provision--although Salem staff do refer when necessary.

"Referral" can have many meanings. At one extreme, it may mean that the family worker gives a parent information about an agency, with the suggestion that the agency might offer the help the family needs. (One CFRP supervisor said, "We make the appointment, if necessary.") At the other extreme, it means that the family worker takes the family, in the program's van or the family worker's own car, to keep an appointment that the family worker has arranged. (In Modesto, it also often means that the family worker serves as Spanish-English interpreter for the parent and agency personnel.) Salem staff, for example, indicated that they almost never do a "straight referral," that the family worker goes along to any agency, especially for the initial visit.

In fact, transportation (to agencies, as well as to the program itself) is listed as a direct service by staff at several CFRPs. Lack of transportation is a problem at virtually all sites. Social service agencies are often located in places that are not readily accessible: in Bismarck, for example, the welfare office is outside city limits; the mental health agency to which the program frequently refers client families is in another town seven miles away. CFRP-eligible families often do not have cars or, at best, have cars that are old and susceptible to breakdown. Many CFRP communities have no public transportation; in others, public transportation is expensive, unreliable, and inconvenient. In Las Vegas, for example, a one-way bus ride costs 80-85 cents; buses run seldom; most buses run to and from the "strip," where many CFRP parents work, but there are few bus lines joining the various outlying areas where the families live and where CFRP and other agencies are located. It is hardly surprising, then, that in Las Vegas and elsewhere CFRP family workers spend a great deal of their time in transit.

At all of the programs, however, family workers continually try to encourage parents, progressively, to: get to agencies on their own; make their own initial contacts and appointments with agencies; find out for themselves where to get the help they need; develop the resources to help themselves. One CFRP supervisor said that her program provides families with transportation to agencies, but if staff begin to feel that the program is being viewed as a taxi service, they draw back from that. On the other hand, a family worker at another program said: "It is often a temptation to tell people how to do things when they need to find out for themselves." In this, as in all areas, "Coping is the ultimate goal."

2.4 Family Types and Categories

CFRP staff recognize that needs and perceptions of needs differ from family to family--in fact, are unique to each family. Therefore, program services must be individualized to meet the particular needs of each family. However, it appears that it is possible to identify types of families that have certain needs in common. Further, needs that are common across family types may nevertheless be experienced in special ways by families of a given type. Types of families here refers to a classification by structure (single- vs. two-parent), employment status of mother (working vs. nonworking), and age of parent (teenage vs. older). There are also some families (of various types) that fall into a special category that has been described as "multi-problem/ high-risk."

Discussions with CFRP staff members indicate that different types and categories of families are in fact viewed as being differentiated by need and as requiring differential program approaches. Therefore, while it is clear that there is considerable variation on these dimensions within types and categories as well, it is useful to examine the ways in which CFRP staff view and serve: single-parent families; two-parent families; families with working mothers; families with teenage mothers; and multi-problem/high-risk families.

Single-Parent Families

The majority of CFRP families are headed by single women (Table 2-2). Many of these have never been married, and may feel that they bear a stigma as a single woman with

Table 2-2

CFRP Families: Structure
(percent)

	N	Single-Parent	Two-Parent
Bismarck	84	38	62
Gering	99	36	64
Jackson	220	65	35
Las Vegas	97	75	25
Modesto	100	3	97
New Haven	85	80	20
Oklahoma City	103	57	43
Poughkeepsie	135	30	70
St. Petersburg	88	85	15
Salem	138	71	29
Schuylkill Haven	135	70	30
Overall	1284	56	44

a child. Others are divorced or separated, and some of these may have suffered a loss of self-esteem as a result of rejection by a man. Many experience a sense of added responsibility in trying to fulfill the dual role of mother and father, although--as one CFRP director put it--this may be "more a problem in what they perceive that society wants them to be" than in the actual demands of parenthood. Nevertheless, it is clear that many such mothers feel acutely a lack of support in such areas as discipline and child care. They become tired, and have no one to relieve them. "They need a night out once in a while," opportunities for adult activities away from their children. They feel isolated and lonely. They need somebody who will offer emotional support. Some also feel inadequately equipped with regard to such practical matters as home repairs and dealing with a landlord.

The financial needs of single-parent families are often particularly acute--although single mothers have the advantage of eligibility for AFDC, and these families may sometimes be better off than two-parent families that do not receive this help. Many single-parent families are without a car, and have no telephone--and this contributes to the problem of isolation. These families are more likely than others to require emergency help to meet food and clothing needs. Further, the advantage of AFDC-eligibility is offset by the feeling that it is demeaning to have to seek and receive such public assistance. Therefore, many of these mothers want to get off welfare and go to work.

What does CFRP do to help? As with all families, CFRP offers single-parent families very direct, need-specific assistance. This includes emergency food and clothing, as well as referrals to appropriate agencies. The major emphasis, however, is on support. In its most obvious form, this means support for the mother from the family worker, including assurances that "It's OK to be single with a family." (In fact, CFRP staff at one site indicated that it may be easier for single parents to implement what they have learned in the program about parenting, because of no interference from a spouse.) Support also means practical suggestions, within the context of parent education sessions or in one-to-one discussions during home visits, on such questions as budgeting, home repairs and landlord problems, how to use public transportation, dealing with stress, child-rearing and discipline. In parent education sessions especially, time management is an important topic, and CFRP staff offer ideas on how a mother can engage a child in whatever she is doing--so that parent-child interaction and household chores need not be mutually exclusive activities.

Support also means that CFRP families interact to support one another. Friendships are formed within the program and continued outside, and CFRP mothers exchange baby-sitting services, transportation, and--at least as important--encouragement. Even within the program itself, center sessions can provide an effective sounding board, and an opportunity for the mother to learn that she is not alone. Participation in center sessions also affords the mother at least occasional opportunities to get away from her children and spend time with adults. In Las Vegas, the grantee agency runs a ceramics workshop which is open to CFRP mothers and which is seen as having a "mental health" function in providing a break from household routine as well as an outlet for creative expression.

Two-Parent Families

A substantial proportion of CFRP families at every site are two-parent families (Table 2-2). That is, the children are living with their mother and their father or a surrogate. These families are served by the programs in much the same way as single-parent families are: the focus is on the mother and the children. With a few outstanding exceptions, father participation ranges from zero to minimal.

Perhaps the main reason fathers are not involved is that they are typically working during the day, when home visits are conducted and center sessions are held. At most sites, some effort has been made to schedule center sessions at times when working fathers could attend them. This sort of effort has not generally met with success. Most fathers will not attend center sessions. If they come once, they will not return--partly because they feel awkward at being so much in the minority. As one CFRP supervisor put it: "Does a man really feel like a man around all these women?" Some programs have tried to mitigate this problem by scheduling special sessions for fathers, but attendance at these has also been very poor. CFRP staff attribute this to a "macho" feeling that child-rearing and parenting are "women's stuff." (The CFRP center in Dallas, Oregon--a branch of the

Salem program--is run by a man, and there is considerably more father participation there than is typical elsewhere). It appears that in some cases the mothers are resistant to the idea of having fathers present. A CFRP supervisor mentioned one woman in particular who did not want her husband involved because CFRP was "her thing." Also, when women in a parent education group are encouraged to give free expression to personal concerns, hostility against men may sometimes be expressed--and the presence of men would at least be awkward, and might well inhibit sharing and discussion.

On the more positive side, fathers often do become involved in such things as making repairs to the center, painting, making toys, and other such traditionally male-typed activities--"as long as it is removed from babies." They are always invited to family nights and social activities, and some do come to these. If the father is present at the home visit (which is admittedly very rare), the family worker will usually try to draw him into the discussion. Many fathers also lend significant support to their wives' participation in CFRP, both emotionally and in such practical ways as caring for the children while the mother attends a program activity.

One of the "outstanding exceptions" to this pattern is a group of Hispanic two-parent families in the Las Vegas program. A number of the fathers in this group participate very actively. The program director said, "A couple of these men know as much about CFRP as any mother." A similar pattern seems to hold among Hispanic two-parent families in the Gering and Modesto programs. It is ironic that it appears these Hispanic fathers do not fit the "macho" stereotype adhered to by many non-Hispanic fathers of CFRP families. The issue is somewhat more complex than that, however. Part of what seems to be going on is that these Hispanic fathers are in fact exerting strong leadership within the family, as would be expected in this cultural group. They see value in CFRP, partly as "a way to Americanize"--and get involved themselves because they do not want outsiders influencing their wives and children in their absence. Conversely, at one other site program staff indicated that they have not been able to "get to" Hispanic families, because the husbands will not let their wives participate. In Las Vegas, the one Spanish-speaking home visitor organizes many special social activities for and with her families, including weekend baseball games, picnics, and trips to the mountains. She brings her own children and becomes part of the group. She encourages her families to act as extended families toward each other. They have become friends, work together, and help each other out. The fathers are no less involved in all of this than the mothers.

At other sites and with other two-parent families, the family worker must work largely through the mother in her efforts to improve the marital relationship, to discuss the impact of that relationship on the children, and even to encourage father-child interaction. When appropriate, a referral will be made for family counseling. Only rarely is there direct contact between the family worker and the father. There is some doubt about CFRP's ability to exert a positive influence on relationships within the two-parent family under these circumstances. One family advocate said: "Sometimes I feel we've been divisive, offering the mother support that's outside the father's realm."

Working Mothers

Working mothers* face the same obstacles to active participation in CFRP as working fathers. Center sessions are held, and home visits conducted, during hours when an employed mother would ordinarily be at work. The major exception to this is Las Vegas, where there are fewer such schedule problems than at other sites because of the nature of the city's tourist industry, which operates around the clock seven days a week, so that an employed mother is just as likely to be off work in the middle of a weekday as at any other time.

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*It should be noted that it is impossible to present an accurate, up-to-date table showing employment status of CFRP mothers. The data indicate that these women move in and out of work--and in and out of the labor force--very frequently, often more than once during a given year.

At most sites, some effort has been made to accommodate the schedule of home visits and center sessions to the needs of working mothers. It is sometimes possible to arrange home visits during a lunch break, in late afternoon or evening, or on weekends--although one family advocate said frankly, "We're not really willing to give up our weekends to give visits." Where this is not feasible, some family workers indicated they might make the home visits with a baby-sitter, if she is the usual caregiver; it is difficult to see how this alternative jibes with a focus on the parent as the primary educator of the child. Otherwise, the home visit is replaced--if at all--by telephone calls and notes left in a mailbox. In general, those programs that have experimented with evening center sessions have dropped them for lack of parent participation. CFRP staff point out that many mothers who work full-time lack the energy and/or the motivation to spend an evening at the center. For one thing, the time mothers have to spend with their children is already limited, and they are typically not inclined to take on an additional activity that requires them to be away. On the other hand, in St. Petersburg, where monthly sessions for parents are held in the evening as well as in the morning, the evening sessions do draw a larger attendance.

Employment of mothers does not appear to present a road block to participation in CFRP in Modesto, which operates a program specifically aimed to meet their needs. Most mothers at this predominantly agricultural site become employed part- or full-time during the May-to-November harvesting season. While the mothers work, their children are cared for in one of four centers operated by the program. Two of the centers serve children from six weeks to two years old; the other two provide care for two- to six-year-olds. Home visits and center-based sessions occur on a regular basis, although with somewhat lower frequency than in the off season.

At most other sites, working mothers are not encouraged to enroll in the program. If they start working after they have enrolled, CFRP staff will attempt to serve them. Clearly, these attempts often fail. One home visitor commented on four mothers who had recently dropped out of the program because of starting work: "This is upsetting, it's almost like a punishment." It is especially difficult for the families of working mothers to remain enrolled after their children reach Head Start age, because at most sites Head Start is not a full-day program. This means that the mother must make alternate care arrangements for part of the day, and also must see to it that the child is taken to or from the day care facility at the appropriate time.

With respect to families with working mothers that are enrolled in CFRP, program staff feel that the financial benefits of employment are often minimal. They report that in many cases the mother makes just enough money to be ineligible for public assistance of any kind. CFRP may then seek to find nonpublic sources of support, such as churches and charitable organizations. At many sites, day care for children--which a single mother requires if she is to work full-time--is typically very expensive, although the severity of the child care problem varies considerably from site to site. In Oklahoma City it is relatively minor; many mothers are able to make arrangements for care by neighbors or the extended family, and the program has a good relationship with a number of day care centers. In Salem, child care--especially quality care, and especially for infants and toddlers--is hard to find, and expensive. In Las Vegas, availability is not a problem, but expense is. CFRP does what it can to help: when the Title XX program opened in Las Vegas, it was quickly filled with CFRP families. At many sites, CFRP staff spend a good deal of time seeking out quality day care at affordable rates.

The one problem all working mothers seem to have in common is a shortage of time. Again, parent education sessions focus on time management techniques. CFRP staff try to emphasize "quality--not quantity" where time is concerned, the provision of a little special time for each child each day. They try to help the mother feel less guilty about the lack of time to spend with her children. On the other hand, they try to make her aware of the importance of being a parent. One family advocate mentioned several CFRP mothers who did not have the energy to be good parents because they were working. She suggested that they quit work and go on welfare so that they could concentrate on parenting.

Teenage Mothers

"They're not grown up. They're minors." A CFRP director used these terms to sum up the special problems and needs of teenage mothers (Table 2-3). Program staff are acutely aware of the fact that these mothers are adolescents who are themselves still growing and developing, yet at the same time must be concerned with the growth and development of a small child. Another program director pointed out that teenage mothers are caught between childhood and womanhood, often still grappling with establishing their own identity. Their infants may be enjoyable, but they are not "real." A mother may dress her child up like a doll, but is also likely to forget the child for long periods of time. Further, teenage mothers often lack the most rudimentary knowledge of child development.

Because these mothers are so young, they also have special needs in such areas as nutrition, health, and recreation. "They want to run around, they don't want to

Table 2-3

CFRP Families: Teenage Mothers
(percent)

	N	Teenage
Bismarck	84	8
Gering	99	10
Jackson	220	9
Las Vegas	97	25
Modesto	100	4
New Haven	85	6
Oklahoma City	103	15
Poughkeepsie	135	3
St. Petersburg	88	3
Salem	138	3
Schuylkill Haven	135	2
Overall	1284	8

have to sit in one place and do things with the kids." On the other hand, one consequence of motherhood for a teenager may be a loss of her place in the peer group, and also a certain sense of power--because of having accomplished a feat ordinarily associated with adulthood. CFRP staff must be exceptionally sensitive with this population. They must be firm in reminding teenage mothers of their responsibility as parents, but not appear to be adults "talking down" to children, or they are likely to encounter adolescent rebellion.

Generally, program staff feel that they are well equipped to deal with these needs. In most programs, a considerable amount of in-service training is devoted to working with adolescents. In Las Vegas, several of the home visitors were teenage mothers themselves, and have particular empathy here. Staff also find it helpful when there are former teenage mothers participating in parent education sessions. In fact, they tend to feel that they should not offer special parent education sessions for teenage mothers, as they can benefit from hearing about the experiences of older parents; this also helps in working out intergenerational conflicts. Home visits with teenage mothers, which can be more individualized, often are addressed to gaps in their knowledge of child-rearing, parenting, and household management. Further, particular emphasis is placed in these discussions on such issues as contraception and drug abuse. Some of the programs do plan special social activities and recreational events for teenage mothers, including disco parties, volleyball and basketball games, and bike rides.

A large proportion of the teenage mothers in CFRP are living at home, with their own parents. This arrangement has obvious advantages in terms of practical and financial support, but it can have its problems as well. Frequently there is conflict with the extended family. The grandmother may be angry over her daughter's pregnancy, for which she feels some responsibility and guilt. She may try to take over the rearing of the child, and this may be resisted. Alternatively, the child's mother may leave the child in the care of the grandmother in order to be free for her own pursuits. Disputes over financial matters are also very common. The teenage mother may feel that the AFDC money is hers because the child is hers, while her mother feels that the money is hers because she is supporting the household. In Las Vegas, particularly, CFRP staff attempt to work with the entire family, and negotiate such disputes if possible. In some cases, however, members of the extended family may resist program efforts to help the mother. A home visitor in Oklahoma City described a situation where members of the extended family were present during home visits and the teenage mother was afraid to talk in front of them. The Las Vegas supervisor indicated that at times the interest of program staff in the mother may make the grandmother jealous.

In many cases, the teenage mother is desirous of getting out on her own and establishing an independent household. Where this is the case, the program will generally try to help, although CFRP will typically not initiate such a move. Many of these mothers have little notion of what is involved in living on their own, and they need a lot of help. In fact, one program director emphasized helping the mother develop a plan for establishing a home, rather than encouraging her to do so if she is not ready--that is, if she has no job, no marketable skills, and is not competent to handle living alone with her child. The discussion might focus on what it is like to live on an AFDC budget, costs of housing and other expenses, and so on. The family worker is also likely to encourage the mother to develop job skills or possibly finish high school before she makes the break.

Many teenage mothers want to finish high school, although they may feel out of place among their school peers. CFRP does all it can to encourage this. The encouragement might include counseling, tutoring, helping to arrange day care, and working with the schools to combat absenteeism and deal with academic and behavioral problems. In Las Vegas, especially, a number of teenage mothers want to continue beyond high school, and program staff will take them to the community college or the university to help them enroll. In some cases they suggest that a mother continue on welfare so she can remain in school.

As with employment, a school schedule tends to conflict with the program schedule--although the conflict is not as severe, given the comparative brevity of the school day and the length of summer vacations. It is often difficult for teenage mothers to participate actively in CFRP. A home visitor in Las Vegas emphasized that she tells the mothers not to skip school to attend center sessions. In Jackson, on the other hand, a number of the mothers attend an alternative school which operates on a flexible schedule and also offers credit for attendance at CFRP sessions. At most sites family workers may be able to make some accommodations in home visit schedules, but teenage mothers who are attending school are largely excluded from CFRP center sessions.

Multi-Problem/High-Risk Families

"Multi-problem/high-risk" can have many meanings. All families have problems and face crises and even, at times, may be "at risk." The variety of possible definitions of this concept is exemplified by the fact that one CFRP supervisor said she thought there were "a few" such families in the program, whereas one family advocate at another site stated vehemently that all of the families she works with (a caseload of over 30) fall in this category. It is possible that the CFRP populations at these two sites are substantially different, and even that this particular family advocate is working with an unusually large proportion of particularly needy and troubled families--but it is almost certain that there is a discrepancy in definitions here. Nevertheless, a number of common themes recur when CFRP staff from different sites talk about families they consider to be "multi-problem/high-risk" families.

- These families often have more children than is typical of CFRP families. The parents have difficulty coping with the parenting task, and may be abusive or neglectful. The children have "behavioral problems."
- There is often familial discord in these families, including marital problems--in the extreme case, a "battered wife." One family advocate mentioned biracial couples who are subject to strong disapproval from the extended family.
- These families are often marked by frequent or chronic illness and problems of substance (alcohol or drug) abuse.
- The parents of these families are frequently lacking in education and in job-related skills--that is, more so than in most CFRP families. Many are mildly retarded or have learning disabilities or other psychological problems.
- These families are particularly needy in an economic sense. They are often lacking in basic necessities. The parents typically are poor money managers.
- These families often live in crowded, ill-equipped, unsanitary housing.
- In general, the parents of these families are marked by their inability to cope with the exigencies of life. They have a "crisis orientation," and the families are constantly in crisis. The parents lack the ability or motivation to set goals and follow through on plans. They have a poor self-concept and are often depressed or even in despair, with no confidence that they can improve their situation.

CFRP staff generally feel that they are fairly well equipped to serve multi-problem/high-risk families. As one family advocate put it, "If the family is willing to take the help, we have a lot to offer." The comprehensive approach taken by CFRP means that where the program itself cannot help, its contacts with other agencies will usually ensure that help is given. The one great lack mentioned by some staff is an economic one: if the family is in dire straits financially, there is little the program can do to help--except, of course, for making referrals.

It also appears that in some cases a family's needs are simply too overwhelming for the program to handle. The Las Vegas CFRP director discussed one case, referred by a court, where both parents were retarded. Program staff visited the family once a day and programmed all their activities. Finally the decision was made that this level of service intensity could not be continued. The infant-toddler specialist in Las Vegas pointed out the danger of neglecting other families for the sake of a few especially needy ones; if this begins to happen, program staff try to get other agencies more heavily involved in the case.

It is not unusual for a family court or a local governmental agency to refer multi-problem/high-risk families to CFRP. In some cases, courts have even granted parents probation contingent upon their enrollment in CFRP; the program then reports to the court on a regular basis. At a number of sites, families are also referred by Protective Services agencies. On the other hand, many multi-problem/high-risk families also come in by the most common route: in response to word-of-mouth "advertising."

Services to multi-problem/high-risk families are not essentially different from services to other families, because these families are not essentially different; they have the same needs and problems other families have, only more of them and/or more severely. The specific help offered depends on the specific problem presented. The fact that these families usually have many problems, however, means that decisions have to be made as to what to work on first. This decision-making process has already been discussed, in connection with the issue of prioritizing goals. As the CFRP supervisor in Salem described it, in working with multi-problem families program staff begin with small problems, until trust has been established. Then parents begin exposing the more serious hidden problems, and work can begin on those. That is, survival needs are put first, and then personal growth. The Las Vegas director also mentioned that the problem of substance abuse must be dealt with before anything else can be tackled. The programs offer immediate help for immediate needs; in St. Petersburg, the Family Counseling Center that runs the program's parent education sessions has a 24-hour crisis hot line. But the ultimate objective for these families, as for all families, is that they learn to deal with their own needs and cope with their own situation on a continuing basis.

There is one special type of problem in some families that does require a special kind of help: the handicapped child (Table 2-4). CFRP staff generally feel that their assessment procedures are adequate to identify such children, and that the programs are well equipped to meet the needs of these children and their families. The director in Jackson did point out that the program is not set up to give direct treatment or therapy, and that they will not accept children they feel they cannot help or who could be hurt, such as the severely disturbed or handicapped. At most sites, program staff receive special training in dealing with the handicapped. Several have access to the services of a specialist in this area. All programs work closely with agencies that are able to provide specialized

Table 2-4

CFRP Families: Handicapped Children
(percent of families)

	N	Handicapped
Bismarck	84	15
Gering	99	10
Jackson	220	21
Las Vegas	97	5
Modesto	100	6
New Haven	85	6
Oklahoma City	103	19
Poughkeepsie	135	5
St. Petersburg	88	1
Salem	138	17
Schuylkill Haven	135	15
Overall	1284	12

services to handicapped children and their families. The Oklahoma City director mentioned that the program will sometimes pay for such services if they are not available free of charge; they also make sure that the reports which parents receive on their children from specialists and agencies are understandable, presented in "laymen's language."

There are some things that can be done to adapt the CFRP program itself to the special needs of families with handicapped children. Clearly, where family workers have received training in working with such children the home visits can be appropriately individualized. In Jackson, when the mother of a handicapped child attends a center session, a volunteer is available to work one-on-one with the child. In Salem, there is a special parent education group for parents with handicapped children. At a number of sites, these parents are helped by means of counseling to deal with their own feelings about the handicap, to understand its impact on the family, and--in general--to cope with the attendant problems. Once again, "Coping is the ultimate goal."

Chapter 3

CFRP COMPONENTS

CFRP services are offered within the context of three major program components--infant-toddler, Head Start, and preschool-school linkage. Each is intended to serve families with children in a specific age group; all three taken together are intended to provide continuity--especially developmental and educational continuity--across the period of a child's life from before birth to the primary grades in school.

Descriptive profiles of the three components are presented in this chapter. Section 3.1 describes the infant-toddler (I-T) component of CFRP. (Similar information is presented in Chapter 2 of the report on The Infant-Toddler Component and Child Impact.) Head Start is the focus of Section 3.2. Information about the preschool-school linkage (PSL) component is presented in Section 3.3.

3.1 Infant-Toddler Component

A view of the parent as the primary educator of the child is an integral part of the CFRP mandate. It is through the parent, rather than by working directly with the child, that the program is expected to enhance the child's growth and development--which is one of CFRP's primary goals. I-T services are provided to families in the context of center-based activities and home visits which involve both parent and child. These two aspects of the I-T component are described in more detail below.

Center-Based Activities

Center-based activities are conducted for families in the I-T component in all eleven CFRPs. In most programs, these center-based activities take two forms; one focuses on parents, while the other is directed toward infants and toddlers. There are differences across the eleven programs in the methods employed within center-based activities, as well as in the frequency with which they occur.

Parent education sessions are designed to provide families with a basic knowledge of child growth and development and to assist them in developing more effective parenting skills. Most programs focus their parent education sessions almost entirely on parents, away from their children. While parents attend lectures, films, or discussions, children are cared for in an infant-toddler room or center. Typically, there is little or no opportunity for parents to work with their children at the center, to practice newly learned techniques, or to observe role-modeling behavior of other adults. Parent-child interaction in most CFRPs is usually limited to getting the child settled in the infant-toddler room or engaging him or her in an activity before joining the parent group.

Parent education sessions in Bismarck, New Haven, and Gering are atypical compared to those held at other sites, in that there is extensive opportunity for parent involvement in the infant-toddler room. This is an integral part of Bismarck's TWIGS (Toddlers With Infants Gaining Stimulation) program, designed to help parents acquire effective child care techniques and to teach them developmental activities that are appropriate to the child's needs. Approximately 50 percent of the parent education session is devoted to having parents work with their children on specific tasks in the classroom. Afterwards, parents receive feedback from staff on their response to the child or discuss tasks the child has mastered. The group discussions that follow focus mostly on topics related to child development.

Active parent involvement in infant-toddler classrooms also occurs in the New Haven CFRP. Parents spend a large portion of the time working with their own children or others who are present before the parent education sessions begin. The setting is somewhat less structured than in Bismarck, where parents work on specific developmental activities with the child. In Gering, center sessions provide opportunities for parents to work with their own children and others, and also to observe several role models (program staff and other parents) working with children.

In Salem, opportunities for parent-child interaction in toddler groups have been offered to selected families--those whose children are lagging behind in their development or who have other special needs. The toddler groups were not operational in spring 1980 due to staff turnover, but plans called for resuming the groups again in the fall--and for all families, not just those with special needs children, to be included on a six-week rotation basis.

Parent education in Salem is not limited to these toddler groups. Groups of parents meet once a week for parent education sessions. At the time of the spring 1980 site visit, these were centered around the STEP (Systematic Training and Effective Parenting) curriculum.*

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*This curriculum was developed by Dinkmeyer and McKay and is published by the American Guidance Service.

STEP is designed to increase parent effectiveness through the use of books, tapes, and discussions. Parents are encouraged to share with others on their attempts to apply concepts covered earlier and the child's reactions to new approaches used. Salem is the only CFRP that organizes its parent education sessions by age groups of children. There are three parent groups, focusing on children 0 to 15 months, 15 months to 2 years, and 2 to 3 years.

Most programs do not use a packaged curriculum for their parent education sessions. Several sites have developed their own curricula based on resource materials from the Harvard Preschool Project, the Brookline Early Education Project (BEEP), or the Verbal Interaction Project, to name just a few. In each program, parent education sessions require and involve a considerable amount of planning. The Jackson CFRP, for example, develops a yearly plan for parent education sessions during the summer months with the help of an interested group of parents. In earlier years, staff circulated a questionnaire to parents to find out about their interests, but have found the joint planning effort more effective. It is common in other programs as well to elicit some form of parent input concerning parent education sessions.

While major emphasis is placed on the parent as the primary educator of her own children, this is by no means the only focus of parent education sessions. In a number of programs, these sessions are viewed as support groups in which parents can share problems and ideas. Others use group sessions to help parents cope better with their circumstances, to acquaint them with and link them to resources in the community, and to assist them in becoming more self-sufficient and independent in providing for family needs. From time to time, parent education sessions will address some of the practical needs that families have, such as family planning, legal services, welfare rights, nutrition, immunizations, fire prevention, and so on. Some CFRPs conduct workshops in addition to regular parent education sessions to cover topics that are of particular interest to parents. The Schuylkill Haven CFRP, for example, conducts a Life Skills Project once every three weeks which focuses on such topics as home management, food couponing, budgeting, or food preparation. This is also the case in the St. Petersburg program, which offers weekly study groups that provide parents with an opportunity to share problems and concerns. Other programs offer workshops in sewing, or arts and crafts. It is not uncommon for programs to invite outside speakers to address these special sessions. The Poughkeepsie and Modesto programs rely on guest speakers for 70 to 75 percent of the sessions. Guest speakers are used occasionally in Jackson, New Haven, Oklahoma City, St. Petersburg, and Salem.

Group sessions for children usually coincide with other center-based activities, to enable parents to attend those activities. The Las Vegas program does not have special child-focused sessions; the children are integrated into one of the regular day care classes for preschoolers which the umbrella agency operates--although from time to time they will remain with their parents for a session which involves both parent and chld. Child-focused CFRP sessions are offered at other sites, and are commonly viewed as providing the children with group experiences and giving them opportunities for socialization and learning to share. In some programs, more emphasis is placed on the acquisition of skills, such as language, cognitive, motor, social-emotional, and self-help.

Child-focused sessions are individualized to the extent possible to meet the special needs of each child. Individualization in a group setting may take different forms. In Modesto, activities are carried out in the context of a developmental plan that is prepared for each individual child. Daily logs are maintained by classroom staff, charting the child's progress and development. Home visiting staff receive copies of these logs to enable them to follow up on center-based activities in the home. In most other programs, there is considerably less opportunity for staff to individualize activities or to work one-to-one with a child. Individual attention is usually directed towards children who have special needs rather than to all children in the group. At a child-focused session in Oklahoma City, for example, staff worked individually with two of the fourteen children who were present that day. One had problems with being separated from her mother, while the other child received help in dealing with strong feelings of sibling rivalry. Meanwhile, other toddlers in the group were engaged in such group activities as storytelling or finger painting, or were involved in solitary play. Activities directed at infants usually involve feeding, diaper changing, settling the child for a nap, and infant stimulation.

Three programs offer more than one type of group experience for infants and toddlers. As noted, the Salem CFRP will resume its toddler groups in the fall; the program also offers regular group sessions for children when parents attend their weekly center-based activities. Schuylkill Haven offers similar group activities for children which coincide with parent education or Life Skills sessions. This program also operates a day care center for children in this age group, under the aegis of CFRP's umbrella agency. This center was established with day care funds in response to an assessment of community needs which indicated a lack of day care facilities for the very young child, posing problems for the substantial number of working mothers who are served by CFRP. Children enrolled in CFRP and day care are visited occasionally by a family advocate who observes in the classroom setting or discusses the progress of a particular child with center staff. In the Modesto program, which serves a population composed predominantly of families of agricultural workers, group activities for infants and toddlers vary by time of year. During harvesting time (May through November), children attend one of two infant-toddler centers five days a week for a total of 8 to 12 hours per day to enable their mothers to join the work force. Children are eligible for such center care when they are six weeks old. During the rest of the year, children participate in center-based activities only once a week.

In four of the CFRPs, the sessions for infants and toddlers are guided by an established curriculum. In Jackson, New Haven, and Poughkeepsie, the curriculum is the same as that used for home visits (see discussion of home visits below). Modesto uses the California State Preschool Curriculum for infant-toddler sessions, but not for home-based activities. It is not uncommon for home visiting staff to participate in infant-toddler sessions. Home parent teachers in Jackson, for example, direct the classroom activities with the help of staff or parent aides. Home visiting staff also are involved in Bismarck, Gering, New Haven, Poughkeepsie, and St. Petersburg. Separate staffs are used for child-focused sessions in the other five CFRPs. Each program has developed special mechanisms to ensure some level of continuity between center- and home-based activities, either in the form of records or periodic meetings with appropriate staff.

Frequency of center-based activities varies from site to site. They occur most frequently in New Haven, where families are invited to attend twice a week. St. Petersburg families participate in monthly I-T sessions and weekly study groups. Most CFRPs hold sessions either weekly or twice a month (Table 3-1). In the Modesto CFRP, frequency of parent education sessions varies. Sessions take place twice a month during the harvesting season; in the off season, parents get together for a session every week. Modesto is the only program in which parent education and child-focused sessions do not coincide: children are expected to participate in at least one session per week, but it is up to the parents to decide when to bring their child on any of five days that the center is open. New Haven has a similar arrangement for their I-T groups, which are offered four times a week; families adhere to a regular schedule, however, rather than coming whenever they want. In all programs except Modesto, parents must accompany their child to the center as a general rule.

Table 3-1

Frequency of Center-Based Activities

	2 times/ week	Weekly	3 times/ month	2 times/ month	Monthly
Bismarck		x			
Gering			x		
Jackson				x	
Las Vegas				x	
Modesto		x*		x*	
New Haven	x				
Oklahoma City				x	
Poughkeepsie				x	
St. Petersburg					x
Salem		x			
Schuylkill Haven		x			

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*Frequency of parent education sessions varies depending on season. At harvest time, sessions occur twice a month; weekly sessions are offered in the off season. Children come to the center once a week in the off season, five days a week at harvest time.

Attendance at center-based activities is viewed by staff in most programs as being "less than optimal." In Oklahoma City, this means that only about a third of the families come to the center regularly; Schuylkill Haven has about a 50 percent attendance rate. Participation appears to be a problem at other programs as well, even though staff had difficulty estimating attendance rates. Some families come to sessions regularly; others do not participate at all or attend occasionally. This is also evident from participation records obtained on evaluation families at five of the impact study sites.* It should be noted, however, that staff at a number of the programs have indicated that evaluation families participate less than is typical for CFRP families in general. This is attributed to the fact that different recruiting procedures were used for evaluation families and that, as a result, these families are less committed to the CFRP concept than are those who come to the program voluntarily to seek help.**

About two-fifths (39%) of the evaluation families participated in center-based activities at least once per quarter on average during their first 18 months in CFRP (Table 3-2). Attendance was particularly problematic in Oklahoma City and Las Vegas, where less than 20 percent of the evaluation families came to center sessions one or more times per quarter. In Oklahoma City this undoubtedly is due to the fact that center sessions were not offered for some time during the first year and a half; center-based activities were resumed in the winter of 1980. Problems with center attendance in Las Vegas can be attributed to characteristics of families that were selected for the evaluation at this site. Many of the teenage mothers in the evaluation

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*New Haven was excluded due to high incidence of missing participation data

**In Phase IV of the CFRP evaluation, we plan to collect data on non-evaluation families to examine differences in participation rates between the two groups.

Table 3-2

Participation in Center Sessions
(percent of families)

	Jackson	Las Vegas	Oklahoma City	St. Petersburg	Salem	Overall
N	38	36	30	34	39	177
At least once per quarter	61	17	13	50	49	39
Less than once per quarter	39	83	87	50	51	61

sample attend school during the day and are unable to participate in daytime center activities. Center participation was less problematic in Jackson, St. Petersburg, and Salem, where 49 to 61 percent of the families attended sessions regularly.

Staff attribute occasional nonparticipation mostly to illness, crises, or emergencies that prevent parents from attending. However, chronic nonparticipation on the part of some families represents a problem for all programs. Some mothers simply do not wish to join a group or do not believe they will benefit from being involved. Others consider it "too risky" to attend or lack the necessary support from husband or family. The Las Vegas program, with its large teenage population, at times invites members of the extended family to parent education sessions in an attempt to alleviate this problem.

Participation is particularly problematic for mothers who are employed or attend school during the day, when center-based sessions typically take place. Gering and St. Petersburg are the only programs that conduct evening parent education sessions on a regular basis--once a month--to accommodate the working or in-school mother. In other programs, evening sessions are a rare occurrence. Some programs that have tried them found that participation did not increase; parents are simply too tired after a full day of work or school to attend, or do not want to take even more time away from being with their children.

Nonparticipation does not appear to be due to differences between the child-rearing philosophies of the programs and those that parents hold. A number of programs described their philosophy as providing parents with different options for raising their child and letting them choose an approach that is most appropriate for them. Others noted that there is little conflict because parents play a major role in deciding what is covered in the sessions. This is not true in all programs, however. Modesto, for example, is trying to change some deeply rooted parent attitudes about teachers and schools which traditionally are held by Mexican families. These parents simply do not believe that they can contribute to a developmental or educational program, or should influence the schools. A director of another CFRP indicated that philosophies about child-rearing may not be consistent when families first enter the program, but that it is simply a matter of time before parents realize their own importance; the rest then falls into place.

Programs are using a variety of approaches in an attempt to increase participation in center-based activities. Three CFRPs--Gering, Jackson, and Schuylkill Haven--offer some sort of incentive either in the form of door prizes, certificates or awards for attendance or stamps which can be redeemed for toys, a trip to the zoo, a book on child development, etc. All programs except Modesto provide transportation to center-based sessions for parents who could otherwise not attend; this is not necessary in Modesto, as sessions are held in the housing projects where most of the families live. Several programs hold their sessions in more than one location to make them more accessible and reduce travel time and cost. Oklahoma City just recently opened a second infant-toddler center in the hope of increasing participation of urban families. Poughkeepsie operates five satellite programs which are connected to Head Start.

Frequently family workers will call parents to remind them of the sessions or send out newsletters, calendars, or flyers in an attempt to improve attendance. It is not uncommon in some CFRPs for staff or parents to call those who did not attend to find out why and tell them about the session. Bismarck, on the other hand, uses an "excused absence system": parents are required to call the program to let staff know they are unable to attend.

Two CFRPs--Jackson and Modesto--have established policies concerning participation in parent education sessions: technically, families can be dropped from the program for irregular attendance. The policies do not seem to be strictly enforced; it appears, however, that they may positively influence attendance rates. As mentioned previously, a higher proportion of the evaluation families in Jackson participated at least once per quarter in center sessions compared with families at the other four programs for which such data were available. Other CFRPs do not have policies concerning participation, believing that it should be left up to the family, or that parents cannot be forced to attend. However, some staff do express the view that there should be a certain minimum level of commitment by all parents enrolled in CFRP.

Table 3-3 shows the frequency of participation in center sessions only for those evaluation families who attended at least once per quarter on average. Most of

Table 3-3

Center Participation per Quarter (percent of center-based families)

	Jackson	Las Vegas	Oklahoma City	St. Petersburg	Salem	Overall
# of Sessions Offered per Month	2	2	2	1	4	---
N of Families	23	6	4	17	19	69
# of Sessions Attended per Quarter						
1	35	33	75	6	21	26
2	26	50	0	35	16	26
3	17	17	0	18	16	16
4	13	0	0	12	16	12
5	4	0	0	6	26	10
6	0	0	0	0	0	0
7	4	0	0	12	0	4
8	0	0	25	0	5	3
9	0	0	0	12	0	3
Mean # of Sessions Attended per Quarter	2.77	2.23	3.21	4.28	3.81	3.41
S.D.	1.60	.79	3.75	2.51	1.99	2.12

these families (68%) attended one to three sessions per quarter; very few participated in all the sessions that were offered. (St. Petersburg is an exception, possibly because the attendance data reflect participation in monthly parent education/infant-toddler sessions and weekly study groups.) Overall, families who came to the center regularly attended an average of 3.4 sessions per quarter. Mean attendance ranged from a low of 2.2 sessions in Las Vegas to a high of 4.3 in St. Petersburg.* Participation rates of other families in the evaluation sample (those attending less than once per quarter) averaged .24 per quarter, or about one center session every 12 months.

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*Participation rates reported in this chapter are considerably higher than those included in the Phase II Research Report. The difference is attributable to a change in procedures used to compute participation rates. Participation rates reported are averaged over those quarters for which data are available.

Home Visits

In general, home visits do not represent a continuation of the curriculum or activities presented at center sessions. In most CFRPs, there is no explicit attempt to follow up on center-based activities in the home. For one thing, while an effort is made to adapt center sessions to the needs of those present, they are nevertheless group sessions. Home visits, on the other hand, can be highly individualized.

Home visits have a dual focus in most programs. According to staff, they are designed to strengthen parenting skills and help parents become more effective in their role as educators. They also provide a forum for assessing family needs, setting goals, and helping families to implement their individual family action plans. Home visits typically involve finding out how things are going, discussing special problems and concerns, and making joint decisions with the parent concerning appropriate ways of dealing with the issues at hand. From time to time, the family worker will refer the family to an agency in the community for help with a special need.

There appear to be differences among the eleven CFRPs in the relative emphasis that is placed on parent education/child development and on family needs in home-based activities. Schuylkill Haven is an example of a program that focuses its home visits almost entirely on family needs. In contrast, Oklahoma City family advocates report spending a considerable portion of their time working with both parent and child. Most programs do both. In Bismarck, regular home visits tend to revolve primarily around family concerns, but the infant-toddler teacher will make a special visit with a developmental focus to any family with a particular need in this area. As noted in Chapter 2, in Jackson and New Haven each CFRP family has regularly scheduled visits from two family workers with differing responsibilities. One staff member (a home parent teacher in Jackson, a home visitor in New Haven) works with the parent and child on parenting skills and developmental issues; the other (a family life educator in Jackson, a family advocate in New Haven) is primarily concerned with family needs. At all other sites, one family worker is charged with both responsibilities.

It is difficult, however, to get an accurate picture of the focus of home visits from staff interviews alone. In order to determine commonalities and differences in home visit emphasis across programs, it will be necessary to conduct home visit observations as part of the ethnographic study and/or during Phase IV of the evaluation.

From discussions with staff, it appears that parent education activities provided in the home setting typically involve helping parents to use elements in the child's environment as teaching tools and to turn everyday experiences into constructive learning situations for the child. Parents are reminded about the teaching potential of all household tasks and the many objects in the home that can be used as instructional materials. In some programs, staff bring specific activities into the home to do with both parent and child. Usually the activity is preceded by an explanation of its importance and how it fits into the overall development of the child. An attempt is made not only to demonstrate activities to the parent, but to get her actively involved in working with the child. Frequently, a different set of activities is selected or planned for each family to ensure that they are appropriate to meet specific parent or child needs.

All programs conduct periodic assessments as a check on the child's development. According to staff, the results are used as a basis for modifying the content of future visits. Among the most commonly used assessment tools (Table 3-4) are the Learning Accomplishment Profile (LAP), the Denver Developmental Screening Test (DDST), and the Portage checklist. In two programs, the type of assessment tool used depends on the age of the child. Salem uses the DDST for children up to two years of age, and the Boyd for children between the ages of two and four. Modesto uses a similar approach; infants are assessed using the Koontz, while preschoolers are given the Thorpe assessment tool. Poughkeepsie staff have developed their own assessment based on items in the DDST and LAP. It is a descriptive rather than an evaluative tool that helps both parent and staff to track the development of the child. It is accompanied by extensive notes to give parents an in-depth understanding of

Table 3-4

Type and Frequency of Child Assessments

		Frequency		
	Assessment Type	2 times/ year	Yearly	Other
Bismarck	Portage	x		
Gering	DDST	x		
Jackson	Portage	x		
Las Vegas	LAP			x
Modesto	Koontz (infants) Thorpe (preschoolers)	x x		
New Haven	LAP		x	
Oklahoma City	DDST	x		
Poughkeepsie	Assessment developed by program			x
St. Petersburg	LAP			x
Salem	DDST (up to 2 years) Boyd (2-4 years)	 x		x
Schuylkill Haven	Developmental checklist	x		

the meaning and importance of items covered. Results of assessments are also shared with parents in Jackson; the forms that are used clearly show a child's progress and/or problems relative to Portage norms and to the child's previous assessments. Assessments in Poughkeepsie take place five times during the first three years of the child's life; the most common frequency for assessments is twice a year.

Four programs use a curriculum to guide home visit activities. In New Haven, the curriculum is based on materials developed by Lally and Honig. Poughkeepsie's curriculum corresponds to areas covered in their developmental assessment tool. Home visits for infants up to six months focus on physical development. The next four months are devoted to the social and emotional development of the child. At 10 months, the focus shifts to cognitive development, followed by language development when the child reaches 18 months. Development of self-help skills starts to be addressed at 33 months. Jackson and Las Vegas both use the Portage curriculum, although not to the same extent; it appears to be used more extensively by Jackson home visiting staff. This is due in part to the fact that home parent teachers in Jackson are concerned only with child development and parenting, whereas in Las Vegas--as in most programs--home visitors fulfill a dual role, with home visits covering both parent education and family needs.

In the seven CFRPs that do not use a curriculum, home visits are planned by home visitors or family advocates themselves. In three programs this effort is closely supervised. Modesto's coordinator of child development regularly reviews each lesson plan and provides feedback to staff. In Gering, the I-T specialist serves as a resource to home visiting staff and assists them in their planning activities.

A teacher from the TWIGS program in Bismarck has similar responsibilities. At the other four programs, home visiting staff rely heavily on each other for ideas or recommendations on how to deal with particular issues or concerns. In most cases, there are also other staff to whom home visitors or family advocates can turn for assistance or ideas.

Frequency of home visits varies from site to site (Table 3-5). Family workers in Jackson have by far the most contact with I-T families; home visits take place three times per month--twice by the home parent teacher and once by the family life educator. Three programs make home visits twice a month, and two make monthly visits. In the other five programs, home visit frequency varies. Salem families, for example, are visited either weekly, twice a month, or monthly, according to an agreed-upon schedule; the schedule depends on level of family need and interest as determined in the assessment process. Similar variations in home visit frequency are common in Bismarck, Gering, New Haven, and St. Petersburg. In St. Petersburg, only families enrolled in the "home-based" program have a regular home visiting schedule, with contact occurring weekly or twice a

Table 3-5

Frequency of Home Visits

	3 times/ month	2 times/ month	Monthly	Varied
Bismarck				x
Gering				x
Jackson	x			
Las Vegas		x		
Modesto		x		
New Haven				x
Oklahoma City			x	
Poughkeepsie		x		
St. Petersburg				x
Salem				x
Schuylkill Haven			x	

month; this program serves families who do not participate in center-based activities, and is designed to help them strengthen their parenting skills.

Home visit frequency appears to be influenced by the use of a curriculum or availability of a specialist for help with the home visit planning effort. As noted in Table 3-6, fewer home visits are made to families in those programs where staff are responsible for developing their own home visit plans. Perhaps this is because these staff must devote considerably more time to planning than is the case in other programs.

There is also a relationship, although not as strong, between home visit frequency and family worker caseload. The number of families a home visitor or family advocate is assigned to work with ranges from a low of 12 to 15 in Gering to a high of 25 in the Poughkeepsie and Schuylkill Haven programs. Caseloads in Poughkeepsie include about 8 to 9 CFRP families; the rest are families enrolled in Head Start.

Table 3-6

Relationship Between Home Visit Frequency and Curriculum*

	Frequency	
	Once/ month	More than once/month
No curriculum or specific help		
Oklahoma City	x	
Schuylkill Haven	x	
Curriculum		
Jackson		x
Las Vegas		x
Poughkeepsie		x
Specific help		
Modesto		x

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*Programs with varied home visit frequency were excluded from these analyses.

Family life educators in Jackson serve an average of 31 families each; the services they provide, however, are more narrowly defined than for other home visiting staff. Home parent teachers in Jackson serve 14 to 16 families each. As would be expected, home visits take place less frequently if caseloads consist of more than 20 families. This does not apply to the Las Vegas program, however, which has a biweekly home visiting schedule in spite of an average caseload of 22 families.

Participation in home visits is considerably higher than in center-based activities, as reflected in data on evaluation families in the five impact study programs (excluding New Haven). Home visits occurred on the average about four times per quarter, although, as with center-based activities, there was considerable variation in frequency across the five sites.* It ranged from approximately two times per month in Jackson to about once per quarter in Oklahoma City. There is an obvious discrepancy between the home visit frequencies reported in staff interviews and those reported in participation records. Without exception, home visits to evaluation families occurred less often, on the average, than called for by the schedules described in staff interviews.**

Contrary to expectations, home visits occurred less frequently (about once a month) with families who participated less than once per quarter in center-based activities than with families who came to the center regularly. The latter group of families were visited about two times per month (Table 3-7). Only in Las Vegas was the mean home visit rate about the same for the two groups of families.

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*Participation rates reported here are higher than those included in the previous report. See footnote on page 62 for an explanation of different procedures used to compute rates.

**As noted earlier, this may be because participation levels of evaluation families are atypical.

Table 3-7
Home Visit Participation per Quarter
(percent of families)*

	Jackson		Las Vegas		Oklahoma City		St. Petersburg		Salem		Overall	
	Center	Non-Center	Center	Non-Center	Center	Non-Center	Center	Non-Center	Center	Non-Center	Center	Non-Center
Home Visits Offered per Month	3		2		1		varied		varied		---	
N of Families	23	15	6	30	4	26	17	15	19	20	69	108
# of Home Visits per Quarter												
1	0	20	67	30	25	73	17	27	5	10	7	36
2	0	13	17	47	50	15	12	7	11	5	9	20
3	4	27	0	10	25	12**	18	13	16	40	9	19
4	13	7	17	13	0	0	6	33	16	25	14	14
5	4	20	0	0	0	0	18	7	26	0	7	4
6	17	0	0	0	0	0	12	7	16	5	17	2
7	17	7	0	0**	0	0	12	0	5	5	13	2
8	17	0	0	0	0	0	6	0	5	10	10	2
9	9	0**	0	0	0	0	6	7	0	0	6	1
10	9	7	0	0	0	0	0	0	0	0	4	1
11	4	0	0	0	0	0	0	0	0	0	1	0
12	4	0	0	0	0	0	0	0	0	0	1	0
Mean # of Home Visits per Qtr.	7.61	4.04	2.33	2.41	2.37	1.68	5.96	3.61	5.80	4.19	5.94	2.98
S.D.	2.36	2.51	1.15	1.01	.88	.70	2.38	2.01	1.77	1.89	2.63	1.86

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*Center families are those who participated in center sessions at least once per quarter; non-center families attended less frequently.

**The underline denotes the number of home visits that are supposed to take place according to individual program schedules.

These differences in home visit rates are somewhat surprising: one would have expected a greater frequency of home visits to families who come to the center occasionally or never, in order to ensure that the families receive maximum benefit from CFRP. It appears that "non-center" families are simply less committed to CFRP; this may be due to a lack of interest or motivation to participate or, in the opinion of parents, less need for CFRP services.*

As indicated in Table 3-7, there was considerable within-site variability in the number of home visits made. Some families in Salem, for example, were visited once or twice per quarter; others saw their family worker one or more times per month. The range in number of home visits was considerably smaller in the Las Vegas and Oklahoma City CFRPs. Several explanations are given by staff concerning these family-by-family differences. One is that not all families require the same level of services; those facing a crisis or emergency tend to be visited more often. Problems in scheduling home visits with some of the families were noted as another reason why home visits occur irregularly. Other families lack interest and choose not to be home at times when family workers usually come.

Programs recognize that periodic home visits and center-based activities will have a direct influence on the child only to a minimal extent. Family workers are therefore encouraged to make clear to the parent, verbally and behaviorally, that it is up to the parents to make the difference. Parents are given to understand that it is important that they continue with activities between the home visits if the child is to reap the greatest benefit.

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*This issue will be investigated further in our Phase III Research Report, to be published in early 1981.

Total Program Participation

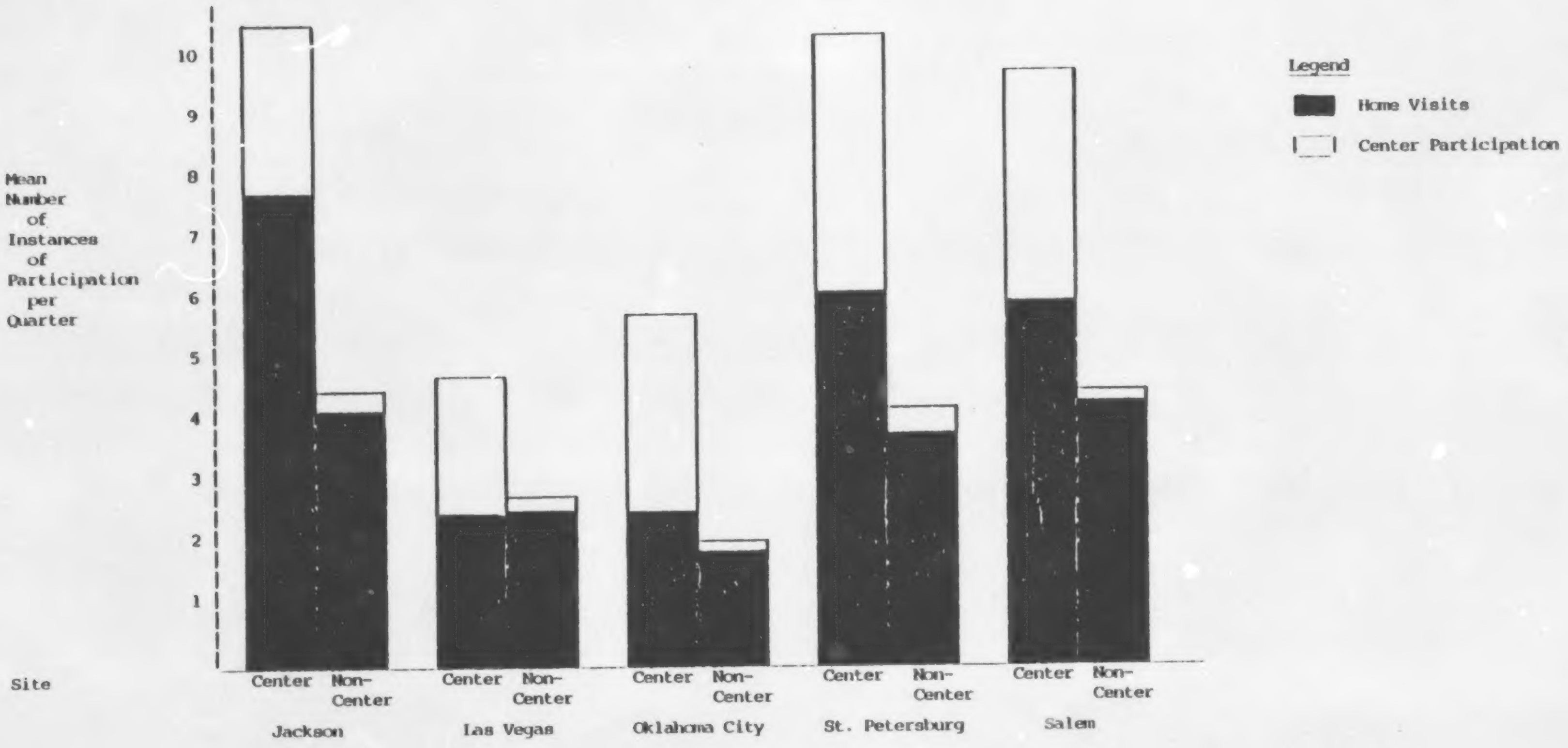
Figure 3-1 summarizes the participation data on evaluation families presented earlier in this chapter. Shown are total participation rates (including center sessions and home visits) for the two groups of families. The term "center" refers to families who came to the center at least once per quarter; "non-center" families are those who participated less frequently in center-based activities. Total participation is consistently lower for non-center families. As is evident from the figure, treatment is considerably more intensive in Jackson, St. Petersburg, and Salem than in Las Vegas and Oklahoma City.

3.2 Head Start Component

While the infant-toddler and Head Start components of CFRP have common goals--to enhance the total development of young children--the methods used to achieve these goals are somewhat different. As noted in the previous section, the infant-toddler component places primary emphasis on working through the parent; Head Start, in contrast, is much more a direct intervention program. The classroom activities that are provided as part of Head Start are aimed at getting the child ready for school and giving him or her a "head start" in life. Head Start is a major operation at all eleven CFRPs.

Detailed discussion of the Head Start program at these sites is not presented here. This component of CFRP is similar to Head Start anywhere else across the country--of which detailed descriptions abound. This section describes the extent to which CFRP and Head Start are integrated at the eleven sites, the transition of families and children from the infant-toddler component to Head Start, and the broad spectrum of services that are provided to CFRP families with children in Head Start.

Figure 3-1
Participation in CFRP



The nature of the CFRP/Head Start relationship varies from site to site, as does the degree to which the two programs are integrated--although in every case they are closely related. The *Phase II Program Study Report* (Volume II, February 1980) identified three models that illustrate differences in the nature of the functional relationship between the programs. One is the "CFRP-as-umbrella" model, typified most clearly by the Jackson Family Development Program--which might be considered just another name for the Child and Family Resource Program (CFRP). CFRP and Head Start are highly integrated in this model; there is one policy council with representatives from CFRP and Head Start, staff functions frequently cannot be distinguished, and counts of CFRP and Head Start families overlap. This model is operational in five programs (Table 3-8). (It should be noted that Gering and Modesto staff report having achieved a *total* integration of CFRP and Head Start, and do not view their programs as representative of the "CFRP-as-umbrella" model.)

Table 3-8

CFRP/Head Start Relationship

	CFRP-as-Umbrella	CFRP-as-Component	Separate Programs
Bismarck			x
Gering*	x		
Jackson	x		
Las Vegas			x
Modesto*	x		
New Haven		x	
Oklahoma City			x
Poughkeepsie	x		
St. Petersburg		x	
Salem	x		
Schuylkill Haven		x	

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*Staff at these two programs indicated that there is *total* integration between CFRP and Head Start.

Another model is "CFRP-as-component," exemplified by the St. Petersburg program. Here CFRP is one component of Head Start, and its coordinator is a member of the Head Start staff. Policymaking for the two programs is the responsibility of a Head Start policy council which has no direct representation from CFRP; however, a representative of the policy council does meet with the CFRP coordinator and carry suggestions or recommendations back to the council for its consideration. Similarly, in New Haven the CFRP coordinator reports to the Head Start director. The "CFRP-as-component" model applies to Schuylkill Haven as well, although this program does have a joint Head Start/CFRP policy council.

The "separate programs" model has been adopted in Bismarck, Las Vegas, and Oklahoma City. Organization charts of CFRPs at these sites show no direct link to Head Start; each program is staffed separately. The Oklahoma City CFRP is strikingly different from the others. It is the only program in which CFRP and Head Start are under the aegis of different delegate agencies. Coordination between the two programs is a monumental task, particularly because the eleven Head Start centers in Oklahoma City and surrounding communities are operated not by one but by several different delegate agencies. Some integration between Head Start and CFRP occurs at only one of the centers, located in rural Spencer, partly because the two programs share offices in this community. Linkages with other Head Start centers are being established, but the process is slow and tedious.

The transition from the infant-toddler component to Head Start is relatively smooth in most programs; children are guaranteed a slot in Head Start, or at least are given priority for enrollment. This is not the case in Bismarck and Oklahoma City, where there is considerable uncertainty about the entry of CFRP children into Head Start due to a lack of integration between the programs. In order to enroll a child in Head Start at these two sites, CFRP families must go through a formal application process, involving a redetermination of eligibility. If family income exceeds the poverty guidelines, the child may be refused entry into Head Start unless the child has special needs, in which case income requirements can be waived. Children who are ineligible for Head Start are frequently referred to other programs for preschool children, such as Title XX day care, which a number of CFRP grantee or delegate agencies operate. Redetermination of eligibility also takes place in the Jackson CFRP, although not necessarily at the time of entry into Head Start; usually it occurs at two-year intervals. This practice runs counter to the "once a CFRP family always a CFRP family" concept--a philosophy that implies that families who are eligible for the program at entry will continue to be provided with services regardless of family income.

Besides ineligibility, there are other reasons why some CFRP children do not become involved in Head Start. The fact that Head Start in all but three CFRPs (Modesto, New Haven, and St. Petersburg) is a part-day program is a deterrent for mothers who are employed full-time. Children of working mothers are more likely to be placed in day care. Other families exercise the option of keeping their children at home until entry into public school. Rather than having the child attend Head Start, families at some sites may participate in a home-based program centering around regular home visits supplemented by periodic center-based activities for adults. Home visits in the home-based option tend to have a strong parent education and child development focus.

Guidelines concerning Head Start entry age are not the same in all eleven CFRPs (Table 3-9). In six programs, children become eligible for Head Start at age three; three programs enroll mostly four-year-olds. In Modesto, children enter preschool centers when they become two years old.

Table 3-9

Head Start Entry Age and Length of Participation

	Entry Age			Number of Years			
	2	3	4	1	2	3	4
Bismarck			x		x		
Gering			x	x			
Jackson		x			x		
Las Vegas		x			x		
Modesto	x					x	x
New Haven		x	x	x	x		
Oklahoma City			x	x			
Poughkeepsie		x			x		
St. Petersburg		x				x	
Salem		x				x	
Schuylkill Haven		x			x		

These preschool centers operate in the same fashion as infant-toddler centers. The children attend classes daily during the May to November harvesting season, and once a week at other times during the year. In New Haven, and to a lesser extent at other sites as well, age of entry is determined by parent preference. Children who enter at the age of four usually participate in Head Start for one year before entering public school; this is not the case in Bismarck, which enrolls four-year-olds for two years, as there is no public kindergarten at this site. Two-year Head Start programs are generally provided for three-year-olds, except in St. Petersburg and Salem, where children are enrolled for three years. (Kindergarten also does not exist in Salem.) Modesto's preschoolers remain in the same center until they enter school at either age five or six.

There also are differences among the eleven CFRPs in the intensity of Head Start classroom experience provided to preschoolers. The number of days children attend Head

Start classes ranges from two days per week in Jackson to five in Bismarck, Modesto, and Oklahoma City. As noted in Table 3-10, in four of the eleven programs the schedule varies depending on the age of the child. In New Haven and St. Petersburg, for example, three-year-olds come to the center two days per week. (Working mothers in St. Petersburg, however, have the option of enrolling their children in Head Start full-time.) Three- and four-year-olds in the Salem CFRP have a similar two-day schedule. When children become older, their classroom schedule increases in intensity. Gering's one-year Head Start program uses a somewhat different approach. In the first semester, children participate for three days; during the second half of the year they come for an additional day.

Table 3-10
Head Start Days per Week by Age Group

	2-Year-Olds	3-Year-Olds	4-Year-Olds	5-Year-Olds and Older
Bismarck	-	-	5	5
Gering	-	-	3-4	-
Jackson	-	2*	2	-
Las Vegas	-	4	4	-
Modesto	5	5	5	5
New Haven	-	2	5	-
Oklahoma City	-	-	5	-
Poughkeepsie	-	4	4	-
St. Petersburg	-	2*	5	5
Salem	-	2	2	5
Schuylkill Haven	-	4	4	-

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*Head Start classes are augmented with home-based activities.

Services provided to CFRP families with children in Head Start, beyond classroom activities for the children, include periodic home visits. These visits tend to focus mostly on helping families meet their needs. This focus is particularly apparent in the Bismarck program, where CFRP is viewed as the "social service" component of Head Start. Somewhat less emphasis is placed on the parent as the primary educator of her own children and on issues related to child development--unless the family is enrolled in so-called "home-based" activities. In Jackson, this means that a home parent teacher works individually with each family once a week, using Portage materials. A combination of home- and center-based activities is offered to families with three-year-olds in Jackson and St. Petersburg. When children reach age four, however, parents in Jackson must choose between the home- and center-based options; in St. Petersburg, there is a shift to a center-based approach for this age group of children.

In most CFRPs, a change in home visiting schedule occurs when children enter Head Start. Home visit frequency is increased in four of the eleven programs. Jackson home parent teachers double the number of home visits for CFRP families with three-year-olds. A similar increase occurs in Oklahoma City, where a team consisting of the family advocate and a Head Start classroom teacher make joint home visits to ensure continuity between home and classroom activities. Each team member has different responsibilities: the teacher reports on the child's progress in Head Start and works with the parent on the child's developmental needs; the family advocate, on the other hand, concerns herself mostly with family-oriented needs. Team coordination is time-consuming, according to one family advocate; another drawback of joint home visits is that it is difficult to work with the family on personal or sensitive matters when there are two workers in the home. Other programs also use the team approach with

CFRP/Head Start families, although advocates and teachers usually visit at different times.

Home visits occur with less frequency in four CFRPs when families move from the infant-toddler component into Head Start. Poughkeepsie is an example of a program that decreases the number of home visits from biweekly to three or four times per year. The decrease is even more dramatic in New Haven, where families with a child in Head Start are seen at home only two times per year. It is important to point out that home visit frequency decreases only if there are no younger siblings in the family. If there are, the infant-toddler home visiting schedule remains unchanged until the youngest child enters Head Start. No change in home visiting frequency occurs in the three remaining CFRPs.

It is common for the same family worker to continue working with the family as it progresses from infant-toddler to Head Start. This practice is followed primarily to provide some form of continuity across the child's early life--one of the mandates of CFRP. There is a change in family worker in Gering and New Haven, where a Head Start classroom teacher is assigned to work with the family at entry into Head Start; little or no contact is maintained by former family workers unless a special need has been identified. A somewhat different staffing change occurs in Salem. CFRP/Head Start families are served by a family advocate/teacher team rather than by a single family worker, as is the case in the infant-toddler component. Assignments to teams are usually based on geographic location of the Head Start center which the child attends. In many cases, this means a new family advocate takes over responsibility for working with the family. To ease the transition, joint home visits are usually made by the new and former family workers until the family is comfortable with the change. A staffing change also is common for Jackson families with four- and five-year-olds who are involved in the center-based option of Head Start. While the family life educator continues to provide services to the family, the home parent teacher no longer maintains regular contact. Classroom teachers take over this function for center-based Head Start families.

In all programs, several other mechanisms are used to provide some form of continuity from infant-toddler to Head Start. Among them are conferences between family workers and Head Start classroom staff when the family enters Head Start. Another common practice is to share records concerning the health status of the child, immunizations, and child assessments with Head Start personnel. Some programs also conduct joint assessments of family and child needs and involve both CFRP and Head Start staff in the development and implementation of family action plans.

Another way of providing continuity across the child's early life is to involve parents in Head Start classrooms as volunteers. This type of activity is encouraged in all CFRPs; some programs, in fact, require parent participation in classroom activities from time to time. It gives parents an opportunity to work with their own children, to become familiar with developmental activities that are appropriate for preschoolers, and to observe role-modeling behavior of classroom staff. All are aimed at strengthening parenting skills and increasing parental involvement in the child's education and development.

Parents also are invited to attend Head Start parent meetings, which typically occur once or twice a month. In most programs, these center-based activities are different from those provided for infant-toddler families. Head Start parent meetings frequently focus on policy-related matters and issues related to center or program operations. Also covered are topics of special interest to parents of preschoolers, such as school registration and parent involvement in schools. In some programs, parents also may participate in special workshops or events that are organized by CFRP and Head Start.

3.3 Preschool-School Linkage Component

The purpose of the preschool-school linkage (PSL) component of CFRP is to maximize educational continuity and to ease the transition from Head Start to public school. A number of things are being done in the eleven programs to accomplish these goals. It is not always clear, however, that these activities are being done deliberately as part of the PSL component; in many cases it appears that they are incidental by-products of the work of some other component--particularly Head Start.

PSL is the least well-developed of the three major CFRP components. In part this is due to the fact that programs allocate only a minimal amount of resources to PSL. This is particularly evident from the way PSL is staffed in the eleven programs. While there is a PSL coordinator in each CFRP, not all devote full time to PSL activities; they commonly have dual responsibilities. Poughkeepsie's coordinator, for example, is in charge of both the infant-toddler and PSL components. Two-thirds of his time is taken up by I-T--the development of lesson plans, and staff supervision and training. Even less time is devoted to PSL in New Haven, where the coordinator doubles as parent involvement specialist for all three components, with responsibility for center-based activities for adults. In Modesto, responsibility for PSL coordination is shared by two staff members--the CFRP coordinator, who devotes 10 percent of his time to this component, and a family resource center specialist who spends quarter-time on PSL-related activities. Only four programs--Jackson, Oklahoma City, St. Petersburg, and Schuylkill Haven--have full-time PSL coordinators.

The various PSL services provided may be thought of as directed at school personnel, parents, and/or children. Of course, as with all CFRP components, the major PSL goal is to meet the needs of children, whether directly or indirectly.

Some contact between CFRP and public school personnel has been established and is maintained at all sites. However, this contact varies in extent and form. At one extreme is Oklahoma City, which did not have a PSL coordinator for a number of years. In spring 1980, this component was just getting off the ground; activities centered around the day-to-day implementation of PSL--finding out what schools children attend and establishing contacts with these schools. Six of the twenty schools had been contacted, and solid relationships had been established with two. Setting up a linkage program takes considerable time, especially for someone without extensive contacts in the educational community. "You don't become an insider overnight," the coordinator noted, especially if school receptivity to PSL is low. Other aspects of Oklahoma City's PSL were still in the planning stages, such as setting up a PSL task force and center-based activities geared towards parents with school-aged children.

At the opposite extreme is the Salem program, which maintains close links with Salem public schools. This is partly because the supervisor of Head Start classroom staff works half-time as early childhood coordinator for the school district. She meets with principals, guidance counselors, and other school personnel to orient them to the needs of young children and the nature of Head Start. She also sends to the schools medical and developmental assessment records of children making the transition from Head Start, along with a note about the child's participation in CFRP. Records of behavioral or developmental problems, if any, are sent to the school and are reviewed jointly by Head Start and school teachers to ensure that problems are addressed promptly when the child enters school. Sharing of records is also common in other programs.

Linkages between Head Start and the public schools are facilitated by other factors as well. Having a school board for a CFRP or Head Start grantee agency, as is the case in Bismarck, Modesto, and New Haven, greatly increases communication and cooperation. The process of establishing and maintaining linkages is further enhanced if Head Start and public schools share the same facilities. This was the case in New Haven until recently. Children typically returned for kindergarten to the same school where they attended Head Start. Public school and Head Start personnel knew each other well. Family advocates served as intermediaries between parents and teachers, arranging for meetings between them or between a child's kindergarten teacher and former Head Start teachers if necessary. This system is no longer in place at this site, since all Head Start centers have been consolidated into one. Family advocates now serve as liaison with the public schools, and direct linkages no longer exist. In Poughkeepsie, one of five Head Start centers is currently located in a school, resulting in effective linkage.

Another way in which communication and cooperation between CFRP and the public schools is facilitated is to involve school officials in establishing policies for CFRP and/or Head Start. The fact that one of the school princi-

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pals was a member of the Poughkeepsie program's parent policy council until recently has greatly strengthened linkages with the public schools there. Las Vegas had a similar arrangement, with the superintendent of public schools serving as chairman of CFRP's grantee agency board. Frequently, CFRP staff are members of school boards or committees and take an active role in school affairs. CFRP in Bismarck, for example, is represented on the superintendent's executive cabinet, as well as on a task force designed to strengthen communications among private kindergarten and first grade teachers. In Las Vegas, the CFRP director serves as a member of a school district committee that was formed to address multicultural issues. The relationship is somewhat less formal in St. Petersburg, where CFRP staff and school principals meet once a year to address linkage issues and concerns.

It is not uncommon for CFRP staff to take on a strong advocacy role with the public schools. Oklahoma City staff, for example, are attempting to reverse a school board decision to close two rural elementary schools. The effects of the proposed school closing would be additional busing of black children (which parents oppose) and reduced access of parents to the public schools, especially because transportation problems abound in the rural community of Spencer. As mentioned in Chapter 2, the Las Vegas program's advocacy with schools is directed towards teenage mothers as well as towards children who have just graduated from Head Start. CFRP staff work closely with school counselors to encourage teenage mothers to return to school and complete their education. They also help to reduce absenteeism, which is frequently endemic with this type of student population. As a result, PSL is well received in this community. The Modesto CFRP, in cooperation with the public school system, is looking towards the development of an "articulated" curriculum; its aim is to ensure greater continuity from preschool centers to the public school and to strengthen the public school's bilingual program.

Other CFRPs are working with school personnel to increase their understanding of the objectives, philosophies, and operations of Head Start. This is accomplished by having kindergarten teachers visit Head Start centers or by providing orientation to school teachers about the program, as is done in Salem. Opening up communications between families and schools and increasing school receptivity towards parent involvement are other commonly stated PSL goals.

One of the major difficulties in establishing and maintaining linkages is the sheer number of schools that are involved in some CFRP communities. The PSL coordinator in Schuylkill Haven, a program that serves a largely rural community, deals with 29 elementary schools that are part of 13 different school districts. While contact has been established with almost all schools attended by CFRP children, this contact is frequently limited to finding out when school registration takes place and overall registration requirements, which differ from school to school. The coordinator relies on parents and on school personnel to bring to her attention problems that CFRP children experience in school. As problems are identified, she will follow up with the school or ask the family advocate to do so on the family's behalf.

The PSL component in Schuylkill Haven will undergo a dramatic change this coming fall. Instead of maintaining minimal contact with all schools, the program will initiate a more intensive PSL effort with two schools attended by a large proportion of Head Start graduates. Plans call for establishing a joint curriculum committee to ensure continuity from Head Start to the public schools. In addition, follow-up on PSL children is expected to take place more regularly than was feasible in the past. At the same time, CFRP hopes to do a more effective job of increasing parental involvement in the public schools. This component could be strengthened further by having a liaison person in each school assigned to work with CFRP and facilitate preschool-school linkages, much like the model used in Project Developmental Continuity (PDC), another Head Start demonstration program funded by ACYF. This view is shared by program directors and PSL coordinators in other CFRPs as well; resource constraints on the part of both CFRP and the public schools have precluded bringing about this type of change.

Services to parents are an essential part of the PSL component. Even if the program has established ongoing relationships with the public schools, parents frequently experience some difficulties in the transition from Head Start. One CFRP director described it as moving "from a warm Head Start to an impersonal school system." Parents may expect the same kind of support that is offered by CFRP, and find that the schools are very dissimilar. To the extent possible, programs are trying to ease this transition to public school, mostly through Head Start orientation sessions. They typically cover such topics as what to expect from the public schools, parent involvement, school policies, current teaching techniques such as new math, and so on. The public schools in Salem conduct similar orientation for parents. The sessions provide parents a forum for addressing issues and concerns with school personnel. In addition, they help parents to feel that their input is valued and that the schools are receptive to their ideas.

Some programs provide more direct assistance to help parents "connect" with the public schools. Staff in Gering accompany parents on their first parent-teacher conference, if requested by parents. They claim that after the initial conference, 95 percent of the parents come to such meetings regularly on their own. In other programs, staff do not go with the parents; instead, they assist in arranging meetings with school personnel. If a special school-related problem has been identified, however, CFRP staff are likely to intervene directly on the parent's or child's behalf.

The importance of continued parent involvement in the child's education--a process started in the infant-toddler component and Head Start--is stressed in all programs. In Las Vegas, this process is facilitated by having teachers periodically fill out a simple checklist on the child's progress. The checklists are sent to CFRP and shared with parents to make them aware of how the child is doing in school and of areas that require improvement. Parents are encouraged to have regular contact with the school and to work with the child on problem areas or assignments that are brought home from school. Bismarck uses an approach similar to Las Vegas' checklist to get a status report on each CFRP child in grades 1 through 3. What is unique about this process is that it involves both parents and teachers, each rating the child's progress independently. Parent questionnaires are completed in the fall, approximately nine weeks after school begins; teachers send in a report twice a year, in both fall and spring. The results are used to determine which students need additional outside help or tutoring to succeed in school. Gering Head Start staff, with the help of parents, have prepared learning packets that encourage and enable parents to work with their children on school-related subjects during the summer months.

In addition to helping parents in the transition to public school and serving as liaison, some programs provide other services to PSL families. Home visits to PSL families are conducted regularly in six of the eleven CFRPs: they occur at least twice a month in Modesto, monthly in

Gering, Jackson, Las Vegas, and Oklahoma City, and three times a year in Schuylkill Haven. Families are visited more frequently, however, if a particular school-related problem has been identified or other family needs dictate more extensive contact with program staff. The home visit schedule also is dependent on the ages of the children in the household; the frequencies reported here apply only to families whose youngest child has started public school. PSL families in Poughkeepsie are visited at home only upon request by the family; similarly, in Bismarck, Gering, and St. Petersburg visits occur when special needs or problems are identified. Only New Haven and Salem report that staff do not make home visits to PSL-only families. It is generally understood, however, that parents can call the program for help if necessary and that the program will assist in whatever way possible. In all except two programs, it is the family advocate or home visitor who maintains contact with PSL families; in Gering and St. Petersburg, this function is taken over by the PSL coordinator.

Even at those sites that have regular home visiting schedules, it appears that the visits themselves are not as comprehensive in nature as is the case in the other two components of CFRP. Reassessment of family needs is considerably less time-consuming and extensive as a general rule. At some sites, no reassessment takes place at all for families in PSL. In part, this is attributed to the fact that families have been in CFRP for several years and require less assistance from the program. It is assumed that many of the family's needs have been met since they entered CFRP or that the program has helped the family to cope with them independently. Except in isolated cases, staff feel that families have made the necessary connections with social service agencies in the community and no longer require CFRP to act as a referral source.

Family contact also is maintained through periodic center-based activities. However, most programs do not have any special parent education sessions for PSL families; the parents are invited to regular center-based sessions and workshops that are planned for the other two components of CFRP. The sessions provide parents with an opportunity to share problems and concerns with other families who have school-age children. Jackson has an extensive parent program aimed specifically at families in PSL. Families participate in monthly sessions focusing on school-related topics. Two parent groups have been formed to accommodate the large number of families that are enrolled in PSL. The program apparently has been received enthusiastically. Las Vegas, Modesto, and Poughkeepsie are three other programs that conduct special PSL parent sessions; the groups get together once every six to nine weeks.

Some PSL services are provided directly to children. At some sites, this involves taking the children to a public school and explaining how school will be different from Head Start. Beyond that, preparation largely consists of having Head Start teachers work with children in the classroom to ease the transition to public school. Another service that some CFRPs provide is assistance in getting children placed in special needs classrooms if that is deemed necessary. Salem has a unique arrangement with the schools whereby testing of children is done by the school psychologist while children are still in Head Start. Without this procedure, it could take as long as five months before problems are identified. Another feature of the Salem public schools is a First Grade Success Plan, open to all Salem first-graders with low scores in school readiness on entry tests. The curriculum is individualized to ensure that special needs of children are met. Similar early identification and placement of children in special needs classrooms occurs in Bismarck, although testing does not take place until children have entered school.

Once the child is in public school, aside from dealing with crises and problems of adjustment, the primary PSL service offered to children takes the form of tutoring. The Jackson program until recently offered 1 1/2-hour tutoring sessions weekly, divided by grade level (one kindergarten group, one first-grade, one second- and third-grade), at the CFRP center. Attendance at tutoring sessions was reported to be extremely high. Due to the loss of a CETA grant, the tutoring program has been reduced drastically. Children no longer come for weekly sessions, but instead are worked with periodically at home by CFRP staff. In-home tutoring is common in other programs as well. If it cannot be provided directly by CFRP, children are referred to community tutorial services to ensure that their educational needs are met. This approach is used in New Haven and St. Petersburg.

One of the strengths of PSL, according to coordinators and program directors, is that the linkages with public schools have resulted in greater cooperation and increased sensitivity to children who have been involved in a preschool program like Head Start. These school contacts, linked with other activities offered as part of PSL (special placements, home visits, tutoring, and parent education sessions), are generally believed to provide the child with a "better chance to succeed in school." PSL also has an impact on the continued involvement of parents in their children's education as well as in school affairs. Program directors and PSL coordinators are quick to point out the limitations of PSL, however. For one, there simply is not enough time or manpower to maintain an effective linkage system with all public schools, let alone establish contact with teachers of each and every child. The limited amount of resources allocated to PSL also preclude comprehensive follow-up on all CFRP children who enter public school.

Chapter 4

CFRP SUCCESS STORIES

Ask CFRP staff members to describe families who illustrate success in CFRP, and most will respond with a question: "What do you mean by success?" or "What kind of success?" Staff are not hedging with these questions. Rather, they are reflecting the single most pervasive characteristic of CFRP: variation among families who participate in the program and variation in the way CFRP serves families. Again and again throughout earlier chapters of this report, variation in families and CFRPs has been described. Families differ in strengths, resources, needs, aspirations, and coping skills. CFRPs differ in content and form of activities, services, staff organization, and expectations for participation by families--and for change in families.

The theme of variation is reflected in this chapter, which presents profiles of several "successful" CFRP families. Staff at each of the six impact study sites were asked to pick a single family that illustrated CFRP success. They were asked to use whatever criteria they felt appropriate in defining the concept of success. Most found it difficult to decide what kind of success (and thus, which family) they wished to present. They stressed that no successful family can be truly representative of all families, and that no one family story is representative of the many ways families are treated in CFRP.* Among the stories are those of:

- A mother with 13 children who eventually became able to make her own decisions about her future and about managing her family--a process which also meant divorce from her husband, described as a "compulsive" gambler who failed to support the family.

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*Staff views on success in working with different families in general are presented in Chapter 2, on CFRP Services.

- A two-parent family which entered CFRP as a strong unit, but with financial problems. The program offered this mother a chance to realize her potential as a teacher, as well as new ways of dealing with her children.

- Two parents, one brain-damaged as the result of an accident and the other stigmatized as "mildly retarded": their struggle to face the possibility of delay in their son's development and their acquisition of new skills in rearing both of their children.

While staff stressed the uniqueness of these family examples and used different criteria for success, they did converge across programs in their broad expectations for what all families should get out of CFRP. As reported in Chapter 2, they said that all families should benefit in two child-related areas: knowledge and understanding of child development and quality of parent-child interaction. All families should benefit as well in a third area which staff call "family development." By family development they generally mean the capacity to cope with and manage the requirements of living and raising a family. All six stories in this chapter illustrate variation on these dimensions and others:

- Stage of family development (coping and management skills). Families are at different stages when they enter the program, often go through different stages during their participation, and are at different stages when they leave CFRP.

- Knowledge of child development and quality of parent-child interaction. Families vary in the degree to which they think time spent on child-related activities is important, or even possible. They also vary in the amount of influence they think they have over their children's development and future.

- Needs and resources. Families may have survival needs for food, clothing, and shelter, or more long-range needs concerning income or education, or for help with marital or child relationships. They also differ in the types of family, social, and personal resources available to them.

- Length and type of program participation. Families vary in the length of time they have participated in CFRP, the time it takes for a relationship to be established, the type of contact (center, home, group) the parents prefer, and the amount of contact maintained after leaving CFRP.

These stories also show how different staff styles and program services may be. Some more common dimensions on which staff differ are:

- The role they play. Staff may function as friends, advisers, advocates, child development professionals, or social workers.

- How they work with families. Staff vary especially in how and how much they work with family members other than the mother and infant, who are typically the focus of their attention.

- Their reliance on services from agencies outside CFRP.

- Their expectations for family development and their view of family success.

While these stories illustrate variation, they also exemplify some common themes in CFRP: the tension between support of and intervention with families; individualization of program treatment; the focus on mothers; and the concern with child development. These themes emerge gradually as details of different stories are compared. However, if there is one single theme which unifies the stories, it is the theme of connection between individuals, some who are part of a family and some who are part of a program organization. It is this connection that mothers and staff members describe as each tells part of the family story, and it is this connection that staff would say is the story of CFRP--and the basis of CFRP success.

4.1 New Haven

Jeanette Lawford* lives with her husband and six children in a run-down house at the edge of one of New Haven's black neighborhoods. She is black, 33 years old, and has been in CFRP since 1977.

Mary Corey was a home visitor in the New Haven CFRP's infant-toddler component until spring of 1980; in order to be eligible for training benefits from Head Start to pursue her degree in child development, she switched to a teacher aide position in a Head Start classroom. She is a former Head Start parent who has been working in CFRP for three years. She is black, in her early 40s, with older children.

Jeanette Lawford

I like to talk. I got lot of chances to talk since I been in the program--on the radio, meetings here and in Washington. I like it, like to talk to people.

I come up in South Carolina--back in the woods. Way, way back, so far back it was nowhere. And I had to work hard. We chopped a lot of cotton, me and my brothers and sisters. And my daddy used to get after us. I didn't want none of that. I got out of there when I was 16 and came north. I don't go back much. My sister lives here, too, but she's the only one. I got to know about the program because of her. She used to take Cecil there when she went and took her daughter. He was four then, now he's six. Then I got Matthew, he's three, and Tanya, she's 22 months. Then the older ones: Alan, Nicola, Delgado, Guilo, and Harold. There's eight of 'em. This isn't a big enough place for us, but I think we be movin', that's why everything is stacked up and in boxes all around. The landlord wants $210 for this apartment and won't fix the holes in the wall or the plaster. There's rats. It's terrible. Someone at the program told us about a house near here, over a couple of blocks. Used to belong to the city. You can buy it for nothin' and get a loan to fix it. We're goin' to do that if it works out. It'd be a good place for us.

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*Throughout these stories, the names of all family members and CFRP staff have been changed to protect their privacy.

If it wasn't for my sister telling them at the program and them callin' me I wouldn't done nothing. I was sittin' here feelin' sorry for myself. Stay home and raise the children, 'cause I don't have no other choice. It was gettin' to me. Once the nurse came and I told her, "Things are gettin' on my nerves . . . I need some help or somethin'," but they didn't do nothin'. I don't know why. My sister said, "You ought to go over there. You can get out, the people's nice." She recommended me to Selma at the program and Selma called up, asking don't I want to come, and sent over someone--Mary. I liked Mary right away.

First time I went, I tell you, I was terrified. I thought, I got this accent and I don't know how to put words in the right places, you know, or how to carry myself or how to dress or act. I never went anyplace except out to buy groceries and to church once on Sunday. It's like I didn't know how to function, I guess. I guess in my mind some way . . . I didn't have the confidence or somethin'. There's a girl upstairs here now remind me of me, like I used to be--sittin' around and doin' nothin', sayin' I can't do this and I can't do that. Just sittin' there daydreamin'.

After a while I felt real comfortable there [at the program]. Went every day for a while. What I couldn't get over there--everyone helps with each other's children. There nobody says I don't touch yours and you don't touch mine. If a child is cryin' and needs somethin' or needs his pants changed, somebody do it--don't matter if it's her child or your child. Now people don't do that--they don't do that unless you pay 'em. Even your own family don't really want to do that. They think they your children and you take care of 'em. You get on the bus with two, three little ones, you don't get no help. People think they workin', they don't have to bother none with you. There, it's not just Selma and other staff, the other mothers do things for each other. It is unusual.

Mary Corey

At the point where we reached Jeanette was the point where she really needed someone. She told me later she liked the way I approached her that first day. I spent a lot of time on her. I really went through and explained all the details of the program. I don't think I forgot anything that day. We were talkin' about her house; she was really depressed about how run-down it was, and how the landlord wouldn't fix anything. And I said, "I didn't come to see about your house. I'll be working with Tanya and maybe Matthew, since he's here." I said, "We all . . . none of us has perfect houses. Mine is junky, too. But I didn't come to look at your house. I came to work with you. . . . "

I went to her home for several weeks before she would come into the center . . . because that's the way she wanted it. She was debating whether to come or not. At this point she was disgusted. She had eight children and she wasn't doing anything for herself or with her life. She was havin' baby after baby. I told her about the things we do and the things we offer. Like sewin' classes. Turned out she knew how to sew really well, so I said, "Well, come in, you can help the other parents learn." Told her about different workshops. . . . I said, "You meet other parents, you get out the house, it's something to do. You can plan what other activities you want. Who knows, you may get in a workshop or something that you like to do." I said, "We have transportation if you need transportation, and we serve breakfast so you don't have to worry about gettin' Tanya around for that." She said, "Well, I can't come 'cause I have Matthew," but I said, "Oh, no, I can register Matthew and he can come with you." Once she came, then she liked it.

Jeanette Lawford

My kids, now, the ones went to the program, they smarter than my other kids. They more advanced than kids who don't go. They can catch on quicker. They have their skills in writing and coloring. Cecil, he's a very good student, and Matthew, he's three but he can tell about colors. Tanya, she's the baby but she pick up a lot fast. They go to the program, then they not babies. They can do things for themselves. I know a lady has three kids, she worries about her husband. But she don't want to do anything to get out of it. She's helpless and her kids are helpless. Her kids put their clothes on backwards and their shoes on the wrong feet. They want you to do everything for them. "Mama do this, Mama fix this."

Cecil can fit himself up and pick up after himself. Matthew may have to put his shoes down on the floor to see which is right and left, but he gets them on the right feet. In the program they have to look after themselves, do their work and pick up after. They have to put their coats on right and pay attention.

Maybe they away from me in the daytime and they know I'm not going to do everything for them. Or maybe I change the way I do things with them. Now if they don't have themselves together they can't come with me. If they lost their comb or their shoes I'm not goin' to look for it. They can't find it, they not goin'. All my kids have responsibilities. The younger ones stay here after school with the two teenagers. I tell them they can't leave the house till I get home, and that's 5:30. I think they do pretty good. My daughter cooks and keeps things picked up. My son washes and hangs out clothes. We have good discussions. I don't believe in lying for them or holding them up to be what they not. I want them to learn and do something for themselves. We sat down and talked all about it, my husband and the kids, when I decided to go to school.

I go to the Academy on Crown Street. Been goin' for seven months and got five more to go. I'm goin' for my beautician license. . . . That's eight hours a day for 2,000 hours to get my training. Then a test from the Board in Hartford. I will go to New York for special training for three weeks. I love it. I wanted to be a hairdresser for a long time. Mary helped me get enrolled. The first time there the same feelings came back, just like when I went to the program. I tried and tried to make those little pin curls. My fingers wouldn't do it. I felt funny. Oh, I cried. I come home at night and just cry. I said, "I'll never get this." And Mary and Selma kept saying, "You can do it. You can be something, girl." Then I thought, "There Selma is, bein' in charge at the program and still goin' to school at night. If she can do it, I can do it." For a while I took classes at Hillhouse School at night, but stopped because it was too much time away from the kids. Now I go on Saturday morning, and I will have my GED pretty soon.

Mary Corey

She changed a lot. Before she was, well, I guess you'd say kinda sloppy, just like she didn't care or she was just down. She had nothing to look forward to. So now she's learning all these things about how to take care of your body and how to use makeup, so she's doing those things for herself. She lost weight and she just really looks good. And she's really happy.

She wanted to do something with her life, wanted to have something to fall back on. So when she got signed up for the Academy I said, "Well, you still want to come in and be part of the program." She said her husband . . . he works nights and he could bring Tanya, and some days she could come to keep in touch.

I told her I admire him [her husband] 'cause he really does help. He come out with Tanya sometimes, but he says there's too many women at the program . . . he just doesn't feel comfortable around a lot of women. But he does help. That is a strength that the family had: her and her husband was close. He takes the children to school or picks 'em up and does other things with them. Sometimes he would come with her to infant-toddler, but he wouldn't stay. I'd always say, "Sometime you're going to come and we're going to have the male image in the classroom," and he'd always laugh and say, "Well, no, not yet." He'd come and stay for a little while with Tanya. He's real close with his kids.

Jeanette Lawford

My husband encouraged me to go on. Some men feel like "I put in the work and that's it." He works nights, but he is good to help out. He takes Matthew to Head Start, and he be with the kids sometime in the daytime. He go to Head Start bowling and take the kids with him. Now that I work in the day, he go to Head Start meetings in the day. Sometime he drive the Head Start van for children and mothers that need rides. He didn't do it before--thought that women are at home and they should do that. But I tell him he's got to, 'cause I can't do it all.

It's a lot of work, but I'm going to get through it. Now I got to get good marks, because the kids help me study and they want to know how I do. One day after I started at the Academy I was late comin' back from break. They give you a ten-minute break, but you got to be back at the end. Otherwise they send you home and you lose the whole day. So me and my friend was gone a little bit too long, and we come back and they say, "You're late. You might as well go home for the day." But I say, "No. No way. You not sending me home. I won't go home. I'm sittin' right here, just stay here until the end of the day. I'm not lettin' my children know their mother got sent home from school." I don't want them to think they can get away with that. So I said no. Said, "You can dock me a day, but I can't go home before school is out. I gotta be a good example for my kids."

4.2 St. Petersburg

Clara Jean Wilton is in her middle to late 40s, black, with 13 children. The Wilton family was enrolled in CFRP from 1973 through most of 1975. Mrs. Wilton has maintained contact with their home visitor, Oria Nugent, in the years since they officially left the program. Mrs. Wilton was hesitant about having her interview taped, so the Wilton story is told here by Mrs. Nugent.

Oria Nugent has been a home visitor with the St. Petersburg CFRP since it began in 1973, although her previous experience was as a classroom teacher of preschool and kindergarten children. She is white and in her early 50s.

Oria Nugent

O.K. . . . Well . . . going back . . . and going 'way back, because this was one of the first families that was recruited into the program in 1973. At that time the parents were together, but there was a great deal of strife in the family. The father had a job in construction, and he made enough money but very little of it made it into the family . . . he was a compulsive gambler . . . played the dogs . . . and they had 13 children. The problems were so terrible--she was constantly worried about not enough food, not enough clothes, their housing was terrible and they were evicted a couple of times.

Her parents and most of his family were in Georgia; there were only two of his brothers here and they were very much not helpful. And she was . . . she was absolutely friendless when I met her. She was suspicious and jealous of other black women, afraid Mr. W would cast an eye on them, I guess, so she was completely alone. Her dream was to go back to Georgia. But she had health problems, the children had health problems. The oldest, Tracy, is in her early 20s now. Baby Martha was under a year when I started working with them and she's almost seven now. When I realized that, it seemed like I'd known them forever.

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Problems . . . let's see, where to begin. Of course there was the financial. I went to court with her one time to try to get Mr. Wilton to turn some part of his check over to her and that was the judge's ruling, but Mr. Wilton would just come home, wait for the check to come in the mail, and then leave with it.

Housing was always a problem. They owned a house when I first met them, but he was something like two years behind in the payments and they lost it. They moved . . . let's see . . . one move, two moves, three, four, five moves in the two or so years they were in the program. The first house was O.K., but had only two bedrooms. But they were evicted there and moved into . . . well, substandard housing. There was no running water. Mr. Farrow, our program coordinator, tried going to Mr. Wilton at work and arranging with his boss for him to have some time off to look for a place. They wouldn't move out, though. It was a terrible place for children. We finally called the Board of Health to get them out of there and the landlord took off the doors to get them to leave. Then they were in another little house. I will never forget going there for a home visit one day and finding Mrs. Wilton out on the street sitting on--guarding--a pile of their possessions. The children were coming home from school and people were carrying their things out of the house. They had been evicted again. Mrs. Wilton was so distraught I thought she had gone around the bend. She wanted me to call her parents in Georgia, call Tracy, and call a mover. She was ready to move to Georgia right then and there. Finally Mr. Wilton came home. He had found another terrible place for them to stay, but it was a roof over their heads for the night at least. I think the construction company had loaned him a truck.

Mrs. Wilton was severely asthmatic. I'd go there sometimes when we'd have to sit out on the porch because she couldn't get her breath. And she had missing teeth and problems with her mouth, so she didn't eat well and was underweight. The children, too. Of course, baby Martha was always ill. There was something wrong with her . . . the doctors said they suspected cerebral palsy, but she also had chronic emphysema and got sick easily. Two boys needed surgery. I'm not sure what all we did now, it's been so long. . . . I'd have to look at her file:

> . . . tried to get her to counseling at the mental health center because she needed more than I could do, but she wouldn't go . . . didn't want to think she was "crazy."
>
> . . . did a lot with nutrition and got her on food stamps.
>
> . . . got furniture for them a couple of times. . . . Once they had only a studio couch and kitchenette chairs.
>
> . . . got her going to Dr. D, the pediatrician for the kids.
>
> . . . got baby Martha in PARC school--that's the county school for retarded children. The younger ones got into Head Start, of course, and got funds for the corrective surgery for two of the boys.
>
> . . . got her to have a few sessions with Dr. Woolf, the program psychologist.
>
> . . . got one of the boys into a special juvenile services program when he was picked up for shoplifting or something.

Spent a lot of time with the kids about going to school and thinking about their futures. Now two of the older boys loved school. I'd go by early sometimes and they'd be ironing shirts, eager to get to school. They were good students, played athletics, and one was a real leader. But the oldest boy and two of the girls dropped out. There was all this crisis at home, and then that was the early days of integrating the schools and Tracy was going out every day to a school in a . . . hostile neighborhood. I think the younger ones got the idea that school was something that was very difficult, and it was hard to get along with people, and busing was all part of it.

Over the time they were in the program I contacted a lot of agencies. We called in vocational rehab to see about fixing her teeth. We called Social Security and mental health. I called lots of them, but it was like people came in for specific things, but there was not real continuity.

She wasn't one to come to parent meetings or center activities. Most of what we did with the family we did in their home . . . people from the program goin' in. I did a lot of things with the children, of course, in home visits. Mrs. Wilton was interested in academic things for them. She especially enjoyed reading. I'd take in a slide projector and we'd take turns, us and the older kids, reading the captions. She was hesitant about coming to outside activities, but you could always draw her out about her kids. She was interested in what they did.

Finally, she did go to Georgia, the summer of 1975. Just took the younger children and went. We dropped her from the program because we understood she'd moved. She'd been in the program for two years.

I don't know exactly what happened, but Mr. Wilton went to Georgia after her and brought them all back. Things were better, then they got worse again and she separated from him and moved with all the kids in with Tracy . . . in her one-bedroom apartment. You can just imagine the family dynamics. She wasn't enrolled in the program then, but I did see her, and when she separated from Mr. Wilton we got her in touch with the HRS agency and she got a worker. And when she began to go there, we began to pull back out of some of her dependency on this program.

She had talked with me many times about separating, but it just took her a long time to do it. I got her help with legal aid, but it had to be her decision. I felt, "Good grief, take the plunge, you can't be any worse off," but of course I didn't say anything. I knew she loved him . . . to have had all those children and have built that much . . . even though it was a terrible life . . . she loved him. Finally I think she saw that it was either the kids or him--because as long as he was coming in and out she wasn't going to be able to get any assistance for the kids. She finally filed for divorce.

So she didn't reenroll in the program, though her kids went back into Head Start and she would call me on occasion. But she had progressed and done things more on her own. She went back to school and took a cashiering course and then she went and got a job . . . and she did it on her own. We used to talk a lot about it and I took her catalogs about training and talked with her about setting goals. Since she started working, she has become more conscious of setting goals and striving for them. Everyone seems to have become more goal-oriented. She earned enough money to get her teeth fixed, she gained weight and her whole appearance changed.

To me this is the success of her story--that she could rise up again and again from these terrible blows of life and finally make decisions for herself and do for herself. The caring for the children was always there and there had been good relationships with the older kids, but I was always worried about what all those crises had done to them. I don't know what really kept us both at it even after she was out of the program. She had confidence that I could help her and be a support to her family, and I guess I thought I had to live up to that. I did put in a tremendous amount of time. I went with her many times to the doctors or other appointments, and still tried not to encourage that dependency that she was ready to dump on you if you would take it. At the time when the family came in, the program was different, too. You tried to take people and follow them through--take them to the agency, wait with them if necessary, and really follow through with them. Well, you know, I could have spent my whole life with the Wiltons. Now the program's changed focus, and while you care just as deeply I try to make more referrals.

For her, I was a friend and someone she could talk to and turn to, and she had that confidence in me. I feel that I was especially helpful with the children, with two of the older ones especially, getting them turned around about school and what they were going to do. I also got another one into a juvenile program when she dropped out of school, and I think she's ready to go back now. Of all the things about this family, I think it is the children . . . they're happy now and getting along. Mrs. Wilton has her own house now. It's high rent for her, but it has three or four bedrooms, and Tracy has a garage apartment next door with her car, so if anything happens . . . and the older children have gotten older and can be more supportive so they're probably all there . . . it won't be so hard on Tracy now. Certainly the children all look better, too. Just lookin' at them you can tell they're better.

I hadn't seen her for a long time until recently. Occasionally she would call over to the center just to talk. I'd go by once in a while, or like at Christmas, but then I thought, I didn't want this to be an ego trip for me . . . because she's always glad to see me. So I said, "She's managing on her own and doing on her own and--really, just let go." We were talking one day when she called, and she said she had this idea that we could start a CFRP program in Georgia, and I'd be the coordinator and she could be one of the families . . . so you know she still thinks of it.

I was in her neighborhood the other day and just on impulse I went by to see her, and she said that she had woken up that morning and had dreamt about me. Then I got back and here was this letter asking about a success story for our program. Isn't that funny?

4.3 Jackson

The Thomas family, Bob and Bea and their six children, joined CFRP in 1977; Mrs. Thomas has recently taken a full-time job with the program as home parent teacher for families with school-age children. The Thomases are white; they are buying their own home on the outskirts of Jackson.

In the Jackson CFRP, two staff members have regular contact with each family: one (the home parent teacher) helps the parent with child development activities, and one (the family life educator) acts as an advocate for the family regarding needs such as housing or medical care. As several staff members had worked with the Thomas family, the interview was done as a group. Each of four staff members--the home parent teacher, the family life educator, and two supervisors--contribute to the staff perceptions of this story.

The Staff

There were five children when the Thomases joined the program in 1977. Now they have six of their own and they also have a foster child. The child is a neighbor, but won't stay home, and the mother doesn't really care if she does or not, so the Thomases took her in. They have a 15-year-old, a 14-year-old, and the foster daugher is 14, then Barbara, 7, Linda, 5, and Laura, 4 . . . all girls. And there's the baby--they finally got a boy, R.W.--and he's just over a year.

They live in a real good house for them . . . lots of space for the kids and to have a garden--Bea does lots of canning--but the house is one reason they were having financial trouble. They had a loan on it, not a mortgage, so their taxes and payments are really high. Bob works steady, but in a nonunion shop, so he doesn't make that much. They were really worse off than many other families like them, because they made just enough money so that they weren't eligible for most programs, yet they really had to struggle to make ends meet. They were eligible for Head Start, but when there wasn't room for Laura she wanted into the Family Development Program [CFRP].

Bea was looking for something that would get her out, I think. To hear her, she wasn't involved in anything. She says she was doing a lot of talking on the phone, watching soap operas, doing a little crocheting and sewing, and screaming at the kids a lot. Her participation [in CFRP] was tremendous. She's been chairperson of two-thirds of our committees and really does work on them. She was the type of person who sees opportunities and how she can take advantage of them. She took right to classroom training and learned new ways to deal not only with her children, but with other people's children. Now that's interesting, because she already has six children. Sometimes it is hard for parents to learn new things when they've had several children.

And she's resourceful. She can always figure out a way to get something, and she's managed to pull into the program that whole network of people she used to talk to on the phone.

There's been a real progression in the way she thinks of herself and what she can do, in terms of her own skills now and her future. I've seen the change in her dealings with the children, offering the younger ones more stimulation in cognitive areas than she did with the older ones.

Well, I've noticed the kinds of reinforcement she uses. She gives more of it now. And she looks at what other parents do, too. If she sees something that's really wrong she can say, "You just don't do this with a kid this age," and she can get away with it. Other parents respect her as a parent who knows, not a staff. She has a real gift for telling people things and yet not offending them. I've never seen her offend anyone.

Also, it seems she sees herself as being more important in her kids' education. She knows when the kids are having problems and she knows she can make the difference in what she does with the kids. Like there was a problem with Laura in kindergarten. Bea knew that Laura was likely to withdraw under pressure, but she was having a hard time getting it across to a particular teacher so she came to us . . .

. . . and we had to go talk to the teacher because we had had contact with Laura in the classroom and knew what she could do. Bea also realizes it's partly Laura, and is still working with her and not giving up and, most important, giving her positive strokes.

It's also true with her older children. Her older girls don't like school that much. When they were younger there wasn't that much interest in cognitive things. Like Karen will do little things, acting up so that they'll suspend her for a day or so. Bea finally went to the principal and said, "Look, I send her to school, she does some little thing, and you send her home. You're doing just what she wants you to do. You've got to figure out another method." She feels confident now, see, confident enough to talk like that to the principal of one of our larger high schools.

Well, she's one of those people that all of a sudden she's found out she can do things and she's decided, "Hey, if I can accomplish this, this, and this . . . maybe I can do this." She had all those skills, but she didn't realize she had them . . .

. . . and she didn't see them as important. Now that we recognize these as important skills and ask her to share them, she has more feel for herself. First she'd say, "Maybe I'll get training in cosmetology just in case something happens to Bob," and then, "There is no reason I can't earn some extra money part-time, right now," and then, "I'd kinda like to be a home parent teacher for CFRP." Now that's no part-time job, and that's not just in case something happens to Bob. That is for her.

She has decided to go back and get a degree, maybe in child development, but she isn't far enough along to decide exactly what she will do with it . . .

. . . I think she also just likes taking those classes for knowledge sake and what she can use with her own children. I don't think she can think about what's down the road . . .

. . . Well, if I can interject here, I think she has made a cognizant choice. Remember that she was elected policy council chairperson before she or the council realized that she couldn't be an employee and also be chairperson. It was a very hard choice for her. She said she was mad at Bob because he wouldn't make the decision for her. He helped her write down the pros and cons and then left her with the piece of paper . . . here it was 2 o'clock in the morning . . . after much agonizing she decided that her future for herself and her family probably would lie in getting an education and a career for herself.

I don't know where she gets the energy. The job she has takes a lot of time . . .

. . . I think she is running on that new self-esteem right now. She's so pleased to find out that she can do things, that she's a worthwhile person with valid ideas and that professionals, as she sees us, are willing to accept her on an equal basis and are willing to take her advice if she gives it. I go to her for advice many times.

. . . Oh, so do I.

Luckily, Bob is pretty understanding. There have been a lot of changes in their household, and I'm afraid a lot of husbands would have really hit the ceiling. But they have a really good relationship, and I think he's pleased that she is pleased with herself.

He's gotten some fringe benefits. He's got a scholarship for some of the courses here he took, things he could use day to day--like small engine repair, because his chain saw never worked and his lawn mower would quit.

Did you hear what hapened with the assertiveness course? He took the assertiveness course with Bea. I think he orginally took it because Bea wanted him to, but he must have gotten something out of it because he asked his boss for a raise shortly after that and he got it . . . only thing, that put them over the poverty level for WIC.

Bea Thomas

How does Bob feel about the work part? He was all for it when I started out. Sometimes when he finds out that Mama's not at home all the time and supper isn't necessarily on the stove when he comes home, he doesn't go for that sometimes--but it depends on the mood of the day. Some days he says, "Why do you have to be out at this meeting until 9 o'clock?" But that's about his only beef. He likes for me to be out in the community and doing things I want to do.

I've seen a great deal of change in my children, especially my smaller children. It seems that they know more, they're further ahead of my friends' children the same age . . . and they really like school.

Communication is the big thing, family-wise, that's changed. I have three teenage daughters, and I felt they were teenagers so they could function on their own--so I kind of let them go on their own and lost communication with them. Since I've been taking classes and picking up bits and pieces here and there, we've started to communicate. I've found out . . . I don't know how you say it, it's a more interesting household now, because we're all talking, telling our likes and dislikes, instead of keeping them to ourselves. I've gained so much knowledge, I can't believe it.

4.4 Salem

Bonnie and Gene Sanpiere live with their two children on a residential street in Salem. Mr. Sanpiere works part-time and is in training in small appliance repair. The Sanpieres are in their late 20s and are white.

Marie Halpern has been a family advocate with the Salem CFRP for two years; her previous training was in nursing. She is white, married, with children, and in her mid-30s.

Marie Halpern

I first met the Sanpiere family in September '78: Bonnie and Gene and their two children, Jason and Rena. I observed early that mom had some difficulty writing and some difficulty walking. The boy was also small for his age, hard to understand, and developmentally not where I would have expected him to be. As I did some family history things and assessment, I found that Dad had been diagnosed as a child as being retarded, although he never felt like he was and had developed real mistrusting feelings toward experts, toward people who were going to help . . . had been put down a lot as a child . . . felt like people thought he was crazy. He pretty much learned in a lot of ways how to get people to take care of him and how not to fight for himself, and lots of times just got into not doing anything. Bonnie also had had an accident when she was 10 that resulted in some brain damage. She had experienced a lot of similar things in terms of how people thought about her and her abilities and she learned to be a real fighter . . . would not give up, would not quit . . . and also isolated herself some with that kind of thing.

They were real unaware of where Jason was at. It was real hard for them to look at him. The first year when he was 3 we did observation in class, having her in the class watching the child, seeing what other 3-year-olds were like. She went in and out of that the whole year. We were wanting her to see that Jason was somewhat different from other children, and maybe we needed to take a look at that. But the fear of labeling was there, and all those other issues kept coming up. At one time they'd want to and another time they wouldn't. It took them a good share of last year to feel comfortable with that and be able to say, yes, Jason is functioning slower than other children.

Bonnie Sanpiere

I guess I knew he was slow in my heart but I wouldn't admit it to myself. They told me that they thought he was a little bit slow and Marie took me and my husband up to the Crippled Children Hospital. That wasn't until May, but that was where they told us he was 16 months slow, but he's catching up now. Marie . . . I was pretty upset, you know, more than I should have been really . . . Marie was real nice to come over to me every week . . . and be supportive . . . and be a friend, you know. She really cared, you know, and it makes a difference . . . to have friends.

Marie Halpern

We had Jason evaluated at the Crippled Children's Unit at the med school in Portland. They did a complete physical, and the man observed Jason and Bonnie in the classroom. This didn't happen until nearly the end of the year. That was frustrating . . . I wanted it to happen earlier, but looking back I think that had it happened earlier they wouldn't have been ready. When we went it felt like that was something they had chosen to do and were willing to be part of. And it turned out that with all the bad experiences that family has had with professionals, that the trip turned out to be a real positive experience. The people dealt with them really nice, talked to them . . . they felt accepted and not put down.

We found he had a vision problem, too. The whole thing resulted in recommendations for Jason and for parent education things we could do with Mom and Dad. I went back to Portland for training so we could do them in Salem.

One of the things that came out of the referral was behavior modification things. Besides Jason being slow, part of the problem was the relationship between Mom and Jason. Mom tended to give in to his yelling and screaming, which he did a lot of. And he wasn't potty trained and she felt he was just being a rebellious kid. We watched the man in Portland using behavior modification in the evaluation. I didn't really know what Jason could understand and what he couldn't. The man would say something and Jason would scream and run down the hall and the man would just sit there . . . and then Jason would come back. It was real clear that Jason understood what was being said.

That first year my major role was I did a lot of listening and letting them talk. I also dealt with doctors, because Bonnie has some trouble doing that. And there's been real close coordination between me and the gal that does the handicapped group. We share plans and sometimes have joint sessions with the Sanpieres.

Bonnie Sanpiere

Jason does throw fits with the other kids in our neighborhood. We only have about four 6- and 7-year-olds . . . they're girls, and you know how they are about little boys anyway. I know that last year one little girl pushed him several times, so no wonder he screams and yells. But I did talk to her about it and told her I didn't like it. I told Jason the kids don't like to play with him when he screams . . . and I think the situation is improving. 'Course he still has his times . . . I think the whole neighborhood rests a little better because the screaming's getting less.

Marie Halpern

We worked on language this summer and on a schedule we could use in potty training. Sometimes it seemed we weren't getting anywhere. You know, we'd think we were making it and then all of a sudden the parents would turn around and do something . . . and we'd be real aware that it was a hard time for them. This fall Jason was put in the 3-year-old classroom again, and the teachers followed through with the behavior modification. At the beginning of the year he had a real short attention span, tended to be all over the classroom . . . couldn't be involved in projects at all . . . wasn't intellectually involved . . . still wasn't potty trained. Over the year, he isn't screaming in the classroom anymore, he is potty trained. He's able to sit down and participate, take a "no" answer and live with that . . . taking some pride at being grown up.

Bonnie Sanpiere

I really didn't know what kind of a program it would be, but I knew that Head Start would be a good head start for my kids, you know, preschool, and all that. I really didn't know what else the program offered at the time . . . thought I'd try it.

It has given my children help . . . more than that. They've helped Jason so much with his learning problems and they've been patient with him. Last year they kept him back in the 3-year-old class because he was slow, but I'm really happy about it this year 'cause he's doing so much better with his schoolmates. He had this problem with sucking his finger, and I didn't know what to do about it, but the teacher at school said he couldn't serve himself lunch if he sucked his finger, so he gradually stopped sucking it. They've helped him in various ways. I've seen a lot of it when I go to school. They just take his hand when he throws a fit and tell him to settle down, and he does real good and they just handle him real good.

Gene Sanpiere

I can see how it's helped Jace . . . the special attention he's got from everybody. When I was coming to the meetings I enjoyed it.

Well, he's gotten some speech therapy help, I know that, and helped out on his potty training, and I think being around other little boys helped. I think there is some play therapy, and that's helped coordination with his hands and eyes.

Marie Halpern

Some of the changes in the home have been that Mom no longer is into that behavior that makes Jason scream. She was able to give him strokes when he used the potty and got into a little game of hugging him when he did it. The handicapped group has been one of the nicest things about the program for them, I think. She and Gene are both going and are beginning to deal with issues for children with special needs. They're also dealing with how that got in the way for them as parents. They're beginning to get some of that cleared away and can be available for the kids . . . and beginning to look at their relationship, so that Bonnie doesn't always have to be the strong one that takes care of everybody. Gene's wanting to take care of her; Bonnie's wanting to be taken care of.

I feel really nice about the changes I've seen in Jason. I feel there's a good chance that he's a fairly normal child. I don't know that for sure. I feel there was a lack of stimulation in the home and a lack of parents being able to deal with the kids in a way . . . it seemed that a lot was environmental for him, and that has been eased now. Also, that has worked too for Rena. There are some good talking things between her and Mom now. We worked with Rena this summer, too, as with Jason. It seems like the same things that were affecting Jason were also affecting Rena, and now Rena will benefit from the changes with Mom's parenting and with her interaction with the kids.

Bonnie Sanpiere

For me? Well, my husband has a learning disability, and they helped me see it and understand it better And I've got . . . I've kind of got a learning disability, too . . . I had a head injury when I was a kid. They've helped us meet our problems together. Like I say, it's awfully nice to have friends . . . all these people who care about you . . . it really helps you.

I've been so unsure about so many things. I go to baby class one morning a week, and then to another class about what to do with our kids and offer help with raising our kids, and then I go to another class for Jason and that seems to help me know what to do with the kids more. My mother don't live around here, and it's kind of nice to have a second mother here.

I enjoy the friendship . . . everybody cares . . . all the girls care about each other . . . and the staff are so pleasant to work with. I really like it.

4.5 Las Vegas

The Turners live in a home they are buying in a modest neighborhood in Las Vegas. Mrs. Turner works part-time as a bus driver for the Clark County School District and Mr. Turner works as a dealer on the Las Vegas strip. Their six children range in age from 6 to 15 years. They were terminated from CFRP at their request early in 1977. They are black and in their early 40s.

Two Las Vegas staff members contributed to the staff story: the program director, who is the director of both Head Start and CFRP, and the CFRP supervisor. The supervisor has been a staff member of CFRP since 1977, and has held the positions of secretary and home visitor as well as her present position. She was home visitor for the Turners during 1977.

The Staff

Irene was referred to CFRP from Head Start. Her husband, who had been supporting the family, had had a physical problem with his legs and was temporarily unable to work. She really needed to work, but both he and she found it very difficult for her to take over this role in the family. They needed a lot of support from the program during this time. As she worked as a teacher aide in Head Start, she really came to enjoy it. She began to feel that she wanted to maintain her life outside the home. It actually resulted in considerable friction between her and her husband in the beginning. It's not unusual . . . we have one woman who volunteers in Head Start steadily, but we can't hire her because her husband won't allow her to work. With Irene and Melvin, though, it worked out very well . . . very much with the help of the home visitor. He feels good about her working now--and she is still very much the homemaker, taking care of the house and meals and children, but works part-time. It is very important to her.

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Their three youngest children are doing extremely well in school. One who was a slow learner and having some problems is doing very well . . . getting A's and B's. Irene feels it is because of the program.

When I started working as the home visitor in 1977, the youngest was 2 1/2. Irene was very concerned about getting employment. And she did get on-call work as a maid. She wanted Bobbi, the youngest, to go to Head Start, but it didn't work out because the transportation and the hours conflicted with her work hours. When she wasn't on call she would come to the center meetings and really participate, be quite verbal.

She was quite versed with the infant stimulation activities--for cognitive, social, gross motor. I could explain the activity we were going to do and then sit down and observe. I would be there to help with the praises or whatever, but she was able to take that information and really do the lesson plan. She knew what the lessons were about, and was quite good at using household items to reinforce learning. I was quite impressed. . . .

She also wanted to continue with home visits. The father was home at the time and had started at the community college to get his GED. Since then, she too has gone back to get her GED.

Other than employment referrals we didn't need the help of many agencies . . . the dental clinic was all. Apparently when she applied for the job as driver and the school district learned she had worked for Head Start and learned about child development in CFRP, they said she had a job right then and there. In 1979 the Turners said they just didn't need the services of the program any more. She appreciated everything, but someone else could be using us. We were there when she needed us, and they no longer needed us.

Irene Turner

I heard about the program--about Head Start--on the radio. I wasn't working and I thought we might be eligible. Well, for my kids, I wanted them to be, you know, more alert when they'd go to school . . . just sitting here at home watching me clean all day . . . I wanted a little bit more for them. The older ones were going to school and the two younger ones were wanting to go, so I thought this would help--they might be better alert when they started public school.

To me . . . it brought me out and made me better able to relate to people in society. I thought all my life was just cleanin' house, washing every day, going to the grocery store. I could talk, you know, but I was a little shy, kind of thing. I always thought I would say the wrong thing. I would sort of draw back, like into a corner. I always thought I didn't fit. Then once I got involved in Head Start, nobody laughed at you for what you were sayin' and they were friendly . . . everybody was friendly, you know, it started me to . . . I opened up . . . just opened up like a flower and I've been opening up ever since . . . may open too much. It did change me--so much that we started gettin' along bad because I just wouldn't come in and just do house cleanin' no more. I said, "This ain't for me. I'll go out and work and come back on my off days and clean, but as far as staying here every day cleaning house . . . No. I want to get out and mingle with people in society . . . I like that." In other words, I learned what was happening in the outside world. Educationally-wise, too, because I was able to start going to the community college, and working, mingling with teachers, and teacher's aides, with people who had education, you know what I mean? And it helped me a whole lot.

I think for my kids it enabled them to relate better with children, you know . . . with their own peers . . . and to be outgoing, because they were involved in a lot of things, whereas I wouldn't have been able to carry them every time something came up to do. There are lots of kids, like mine, who don't even know that there is an environment they can be in right now, socializing with children and doing all kinds of things.

I loved the program all the way through, mainly for what it did for me. See, when you're on the outside of it lookin' in you can't really see . . . you've got to get in . . . and I've been there. Only problem I have is it should be placed where more people, you know, could know about it.

4.6 Oklahoma City

Mavis Northrup's family was one of the first to enroll in Oklahoma City's CFRP when it began in 1973. In 1977 she moved to Colorado, but she returned to Oklahoma two years later when her father became terminally ill. She is the mother of eight children; four of the children are with her former husband in California. She now lives with her second husband and five children (four of hers and one of his) in a neatly maintained home in Spencer, Oklahoma. She is black, about 40 years old.

Lucy Parker has been a home visitor with CFRP for one year. Before coming to CFRP she worked in the local community action agency, where she helped coordinate local resources for many social, educational, and employment programs. She is black, about 40 years old, married, with children.

CFRP Director

I can remember when Mavis started with CFRP. She was a single parent with a toddler and three other children. She was on welfare, and really detested being on welfare and living in housing projects. She said that early, but she didn't have much initiative . . . she talked a lot, but really didn't do anything. There were many crises in her family, and it took almost a year to get her to a parent group at the center even though we were about three blocks from her home. She was enthusiastic about home visits, but never ventured out to really be part of any group.

I think a lot of it was through the support of the people who visited with her, they helped her see her successes with her children in particular. But the change in her really started when she started coming to parent groups. She began to interact with other parents, to talk about common problems and common goals. The group did a lot with self-worth and setting goals and planning. One of her goals was to move out of public housing, and she did that. She got a nice apartment that was low income, but had things like recreation that she wanted and planned for her children. After a while she began to take more of an interest in herself; she started to change her appearance. Another one of her goals was to get married, and she did that, too. She began to volunteer, and then she became very interested in policy, how it's made, what we do with families and why. She's really gone from being almost totally withdrawn to being the community activist. She's the chairman of the city-wide Head Start/CFRP board and chairman of the Head Start/CFRP parent group. She's also a member of the community action board and the city-county area council. Not that there are no more problems. When she moved back from Denver, she wanted to get involved again; she felt some problems coming on. She asked me if she could get back in the program.

Mavis Northrup

Before I came out here I was locked up in my house five days a week chasing kids, slowly going crazy. [The CFRP Director] and the others showed me where I could get involved. I was worth something more delightful other than housework, soap operas, and chasing kids all day. It took me two years to do it, I made a thousand and one excuses why I couldn't do it. But these people have worked with me, they've worked with my whole family.

They showed me I could do something, that I could be independent, that I could take care of myself. If I needed to talk with someone for 30 minutes, there's someone. I got ready to get married, there's someone. Now on Friday I'll be on the policy council and Jill (former visitor) will be with me arguing about the Head Start budget. Six years ago I wouldn't have known how to spell budget, what to do with a budget. I've got the training now . . . I can stand up . . . I can talk . . . I can do anything. . . . It's gotten me to where one day I might want to go to work. I'd rather not work in a classroom. I'd rather be on the administrative part. Policy to me makes the program work. We've got to teach the parents just how much power they do hold.

It's made a difference to me and it's made a whole lot of difference in my kids. My mother accused me of getting them too independent. I want them as independent as they can possibly be. I want them to be able if something doesn't jibe, they holler. Holler for somebody.

Until people get down in Oklahoma, they don't know how backwards Oklahoma can be. Programs like we're working here, like CFRP, they help so much. Because you're dealing with a set of parents that have been taught that what the teacher, the minister, and the doctor say is final. You don't question it. They've got these rights to say "No, I don't want that." But they don't understand that.

We're dealing with younger parents now, 15-, 16-, 17-, 18-year-old parents beginning to come in now. They need to be trained on what to even do with a baby. And they need to know that they don't have to get pregnant every nine months to be able to get an increase on their checks so they can have more money. They need to know that they're able to get help and go to school and get trained. And get out of that rut. I'm scared that there is going to come a day they go to that mailbox and that check is not going to be in there . . . politics change.

Since we came back to Oklahoma we had this thing with Chris. The thing with Chris is . . . he could communicate with you through mouth and words but he can't on pencil and paper. But he's not hyperactive, he's a 7-year-old boy who likes to wiggle and squirm and bounce and jump and walk. And now he's here in the first grade, they was trying to convince me he had a learning disability. My question was you can't label a first grade child as having learning disability problems with reading and writing if they've never been taught. O.K., so they tested him and they came up with these scores and things. And they had made their evaluation and didn't want to go any farther. This is what CFRP taught me: Question. Seek information. Don't take the first opinion.

Lucy Parker

With Chris, the school had sent her a letter stating, "The results from the test are here, we'll need to go over them with you." So she asked me to come, you know, as a liaison. They were trying to put him in an LD class, so I got a lot of information before we went. I talked to the LD teachers and I found the Public Law 94.142 and hyperactiveness . . . they were also wanting to label the child hyperactive.

The day we went to the school I picked Mavis up. She was so nervous, you know, "All these people they want to label my child and they want to do this and that." She says that because her other son Bobby is 14 and he really is a hyperactive child. So we get to the school and the psychologist is there, the nurse is there, the teacher's there, the principal's there, the LD teacher's there and, you know, everything is in order. They had all the results of these tests. Now you know if a child has any of certain handicaps, like a fine motor problem or hyperactiveness, then he cannot be labelled as an LD child. They didn't have any of these checked, but they did say he had trouble holding his pencil. Mavis had brought statements from the doctors saying he had a fine motor problem, so therefore he was not an LD child. And we bounced words back and forth, you know, and it was one professional's opinion to another, you know, theirs to mine. So we talked and talked and they finally said, "Are you going to sign these papers so that we can put your child in the LD class?" And Mavis looked at me and said, "I want you to answer that question." "Well," I said, "I'll put it like this. I have further resources and I worked with Chris, and on a one-to-one basis it's much better. You know, I don't feel like he's a slow learner or a learning-disabled child."

So I wanted to see if I could find another psychologist, and then I thought that the first step would be to make a visit to the school in the child's classroom. The teacher had me behind this table like a glass observation window, and he . . . I was totally stunned. Because he reacted the way that they said he did. He did everything in a hurry and was very sloppy and he'd get up and down, you know, like he had no control over himself. And then all of a sudden I started watching the teacher. There are 22 kids, and there's no control, and this lady wants to take one kid out she doesn't have time for, put him in another class where there's maybe 10 kids or whatever, where somebody has more time.

Anyway, I brought the family to an assessment meeting at the program, and the team there helped me out a lot, helped me find another psychologist. His findings were that Chris is a child that wants attention, he wants a lot of attention. His recommendation was to put Chris in a private school where he could get some one-on-one attention. It came out that the mother in all this was having problems at home with the father, and she was really pressured and felt like the world was all against her. The older LD child at home was causing a lot of problems. They were living in

Mavis's mother's house, and things with the LD child were so bad that Mavis's mother just left and went back to California. He completely ran her out. It was sort of a crisis in her personal life. She was on welfare and her husband wasn't working, and then he walked out. The gas was off, there's no food and electricity. That's when she came to me with Chris. Like she was saying, "You handle this for me, Lucy, because I've got too many other problems. I've got to deal with my older child, with my husband, I've got to deal with this, this, this--take this problem, you know, and do something to help me with it."

I really feel good about Chris. I did help that child. There were many little things . . . and we found a place for both Chris and the 3-year-old, Tina, to go--they're going to the Catholic school. They'll take both of the kids for $75. With all this, you know, I helped him and he's got a chance now. He's doing much better at home, too, because the setting is different and he has more of that attention he needs. I feel like he was part of my life.

With the other things . . . I tried to help her deal with some of these problems. And Mavis has strengths . . . in her family it always goes back to her. She is a very informed parent. She knew a lot about what she needed to know to deal with the Chris situation, but she also needed support. Mavis is very much settled in her ways and her beliefs. So I could give my opinion, you know, and if she decided it was the way, then she would, but most of the time it wasn't. But I tried to be a sounding board at all times. She took the initiative in getting help to sort out those problems. I felt that was a great step.

I suggested to her to get out of some of the committees she was in. I know we as women, we need our outlets, too, and we need to be able to motivate ourselves by doing something, and she actually gets motivated off these things . . . but I felt she was in too many activities. She couldn't give the child the attention he needed. But that's not to say when she works with her kids she doesn't know. She works with them very well, but she just didn't have enough time to do it. She's up here every day, and when there was all this going on with the schools I saw her two or three times a month at home.

But we got through the hard time. Things are much better now. Her husband's back, and he's working, and we're doing tests with the older child.

Mavis Northrup

Oklahoma's fine . . . Oklahoma's my birth state, but Oklahoma is 50 years behind the times.

There's people who need welfare, cannot go down there and get it. I need food stamps, but I can't get them because my husband works and I get a check from welfare. I'm staying in my mother's home paying her $100 a month because I can't afford another place and we've got two bedrooms with seven people in it with the five kids. It's a problem, because my mother needs her house to herself. My husband and me, we go around and around trying to determine what we're going to do. I've said, "Well, we can't work it, we'll just separate, and I'll take my kids and I can get more help by myself, and you'd get more help by yourself"--that's the way they've got it set up. I could get out with my own kids and get more help with them than I can with him. They don't recognize a family. This program [CFRP] is the only one that recognizes a family.

Chapter 5

CFRP MODELS AND IMPLICATIONS

The purpose of this chapter is threefold: (1) to summarize the findings reported in earlier chapters; (2) to discuss the implications of those findings; and (3) to identify and examine models of CFRP operations. One of the mandates of the CFRP evaluation, and in particular of the program study, is to describe models that could be adapted or replicated in other communities that wish to provide family-oriented child development services. This chapter addresses several research questions which have been posed by the Administration for Children, Youth and Families; where appropriate, these questions are addressed in terms of models. It is not possible to identify or develop a single comprehensive model for CFRP, because of the marked variations in the program from site to site. However, it is possible to identify models of certain aspects or operations of the program that might be adapted or replicated. Descriptions of such models are presented here, along with summary responses to the research questions. It should be noted that some of the questions are answered only partially, or in a preliminary fashion, in the program study; these are addressed more directly, or in more detail, in the process/treatment and ethnographic studies of the CFRP evaluation.

5.1 What Adaptations of the Three Basic Components (Infant-Toddler, Head Start, and Preschool-School Linkage) Are Characteristic of CFRP Models?

A major objective of CFRP is to enhance the total development of children and to provide continuity across the period of a child's life from before birth to the primary grades in school. There are essentially three different approaches that could be used to enhance the development of children: (1) direct intervention with children; (2) parent education to assist parents in their role as primary educators of their own children; and (3) a combination of the two. The second approach appears to have been advocated, particularly for the infant-toddler component, in the national CFRP Guidelines: It is by working through parents and the family as a unit that CFRP expects to influence the development of children. Numerous research studies support this emphasis. The evidence indicates that parent education not only can be an effective strategy in promoting child development, but may be a necessary step if any lasting improvement in the child's functioning is to be attained. The involvement of the child's parents as active participants is critical to the success of a child development program like CFRP.

Infant-Toddler Component

The parent education approach to providing infant-toddler services has been adopted by most local CFRPs, although a few programs use a combination of parent education and direct intervention. It appears, however, that the potential of the parent education approach has not been fully realized at most sites, primarily because parents do not appear to take adequate advantage of the opportunities for parent education that are offered. While the typical contact schedule calls for two home visits and from two to four center sessions per month, most families are involved in program activities much less frequently. Family participation in center-based parent education sessions is particularly problematic, and is viewed by all programs as "less than optimal." In five of the impact study programs, only about two-fifths (39%) of the study families were involved in center-based activities an average of once or more per quarter, although this varied from site to site. Families who attended regularly participated in 3.4 sessions on average each quarter, ranging across sites from a low of 2.2 to a high of 4.3 sessions.

Yet these center sessions are a primary mechanism for delivering parent education services to families enrolled in the infant-toddler component.

A variety of approaches are used by local programs in an attempt to increase participation in center sessions. All CFRPs except one provide transportation for parents who could otherwise not attend. Several programs hold their center sessions in more than one location to make them more accessible. Others offer some sort of tangible incentives, or have established policies concerning minimum participation in center-based activities; these policies appear to have a positive influence on attendance rates.

Two models of center-based parent education sessions within the infant-toddler component are currently in operation at the eleven CFRPs:

- The Parent-Child Interaction Model provides extensive opportunity for involvement of parents with their own children at the center. Center sessions are designed to help parents acquire effective child care techniques and to teach them developmental activities that are appropriate to the child's needs. Classroom staff assist parents in working with their children and provide feedback on parent-child interactions. The group discussions that follow focus on topics related to child development or child-rearing practices.

- The Separate Parent-Child Session Model focuses almost entirely on parents, away from their children. Children are cared for in an infant-toddler room while parents attend parent education sessions. There is little or no opportunity for parents to interact with their children at the center.

The second model is likely to be somewhat less effective, because it relies mostly on lectures and other didactic approaches as methods of parent training. There is little evidence that simply providing information to parents will in itself lead to significant change in parental behavior or skills.* Observation of modeled behavior, which is regarded as a more effective learning tool, is used extensively in the Parent-Child Interaction Model. This model is in place at only three programs--Bismarck, Gering, and New Haven; all others conduct separate sessions for parent and child. Salem is an exception, in that it has offered opportunities for parent-child interaction to selected families with toddlers who have special needs; its regular parent education program involves separate sessions.

Center sessions are not the only mechanism for delivering parent education services to infant-toddler families. A regular home visiting program can be equally effective in helping parents to strengthen their parenting skills and to increase their knowledge about child development. Home visits are an integral part of the infant-toddler component in all eleven programs. There is some question, however, whether visits occur with sufficient frequency to carry out an effective parent education program in the home. The evaluation of the Home Start Demonstration Program, for example, found a strong relationship between visit frequency and school readiness and language development scores of preschool children.** It is evident from program records and discussions with CFRP staff that home visits occur less frequently than the biweekly visits typically called for in local program plans. Furthermore, families who participate in center sessions less than once per quarter receive considerably fewer home visits than families who come to the center regularly. Home visit frequency is dictated to some extent by family worker caseloads: visits occur less often where caseloads exceed 20 families, which is not uncommon in some CFRPs.

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*Bronfenbrenner, U. Is Early Education Effective? Washington, D.C. DHEW Publication No. OHD 74-75, 1974.

**Love, J.M., Nauta, M.J., Coelen, C.G., et al. National Home Start Evaluation: Final Report--Findings and Implications, High/Scope Educational Research Foundation, Michigan and Abt Associates Inc., Massachusetts, 1976.

More frequent contact with families, either at center sessions or in home visits, would probably be more conducive to achieving the overall child development objectives of CFRP.

Aside from issues related to home visit frequency, there is some question whether adequate emphasis is placed on parent education in CFRP's home-based activities. In most programs, home visits have a dual focus: (1) helping parents to become more effective in their role as educators of their own children; and (2) helping parents to meet a broad range of family needs and concerns. There appear to be differences among the eleven CFRPs in the relative emphasis that is placed on parent education and family needs. The evidence suggests that home visiting staff in some programs devote only minimal attention to parent education or child development concerns.

This is not true in all programs, however. In fact, at two sites, the dual focus of the home visit is explicitly recognized, and separate family workers are assigned the responsibility for each aspect. Two different models of infant-toddler home visit assignments are currently in place within local CFRPs:

- The Team Model--employed in Jackson and New Haven--was developed to ensure that both parent education concerns and family needs are addressed adequately in home visits. Visits are conducted by two family workers: one has responsibility for working with the parent and child on issues related to the child's development and parenting skills; the other focuses more broadly on family needs.

- The Single Worker Model--employed at all other sites--assigns one family worker to each family, with responsibility for both aspects of the home visit, child development and parenting issues as well as family needs.

Home visit emphasis is determined to some extent by the type of curriculum that is used to guide home visit activities. Only four programs have adopted a developmental curriculum. In the other seven programs, home visits are planned by family workers themselves. This effort is closely supervised in three of these programs, usually by someone with a background in child development. Family workers in the other four programs receive little or no guidance concerning the types of activities that visits should cover. It is of interest to note that there appears to be a relationship between the home visit planning effort and the frequency with which home visits occur: frequency decreases when home visiting staff do their own planning and have no curriculum or supervisor to fall back on.

The fact that greater emphasis appears to be placed on family needs in the home-based activities of some programs may be related to the background of family workers. Their training tends to be in social work or related fields, rather than in parent education or child development. A substantial proportion (56%) of family workers at the impact study sites perceive a need for additional training in these areas.*

Program activities are not limited to home visits and center-based parent education sessions; all CFRPs conduct some type of group sessions for infants and toddlers as well. Their purpose is two-fold: (1) to enable parents to attend center-based sessions; and (2) to provide socialization experiences for children, mostly in enriched day care settings. Individualization of activities to meet the needs of each child is limited in most programs. Sessions for infants and toddlers occur with relative infrequency (they usually coincide with parent education sessions), and not all children participate regularly. These sessions clearly were not intended as direct intervention mechanisms in most CFRPs, but rather to supplement parent education services.

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*Phase II Program Study Report, February 1980.

These various factors combined--approaches to parent education, levels of participation in center sessions and home visits, the focus of home visits, and the focus of sessions for children--raise serious questions about the effectiveness of the infant-toddler component of CFRP in enhancing the total development of infants and toddlers.

Head Start Component

In contrast to the infant-toddler component of CFRP, Head Start is viewed as more of a direct intervention program for children of preschool age. The classroom activities that are provided as part of Head Start are aimed at getting the child ready for school and giving him or her a "head start" in life.

Guidelines concerning Head Start entry age are not the same in all eleven CFRPs. There also are differences in the intensity of Head Start classroom services that are provided to preschoolers; they are typical of similar variations in Head Start that can be found nationwide.

In fact, Head Start at these eleven sites is very much like Head Start elsewhere across the country, with two important differences:

(1) Where Head Start is connected to CFRP, there is likely to be greater continuity for children and parents, with a smoothing of the transitions at both ends of Head Start--from the infant-toddler component, and to the elementary school.

(2) CFRP families with children in Head Start continue to receive the broader spectrum of services for family needs associated with CFRP.

In most programs, CFRP and Head Start are closely related, yet the nature of the relationship varies from site to site, as does the degree to which the two programs are integrated. Three models have been identified that illustrate differences in the nature of the relationship between the programs:

- In the "CFRP-as-Umbrella" Model, Head Start is one component of CFRP. This model is typified by a high degree of integration between CFRP and Head Start.
- In the "CFRP-as-Component" Model, CFRP is a part of Head Start and is under the direction of Head Start staff.
- In the "Separate Programs" Model, there is no direct link between the two programs; each is staffed separately.

At some sites, the organizational model appears to affect continuity at the point of transition from infant-toddler to Head Start. In two of the three cases where the "separate programs" model is in place, there is considerable uncertainty about the entry of CFRP children into Head Start. Families must go through a formal application process, involving a redetermination of Head Start eligibility. At all other sites, children are guaranteed a slot in Head Start or at least are given priority for enrollment.

At all eleven CFRPs, Head Start is more than a direct intervention program for preschoolers. Classroom activities are supplemented by periodic home visits and center-based parent sessions. Opportunities also are provided in most programs for parents to volunteer in Head Start classrooms. However, once children enter Head Start, there does appear to be a decrease in emphasis on the parent as the primary educator of her own children--even though research studies have demonstrated the importance of continued parent involvement in the child's education in order to avoid the so-called "wash out" effect. The focus of home visits, even more than in the infant-toddler component, is mostly on helping families to meet their needs. This focus is particularly evident in some programs where CFRP is viewed as the "social service" component of Head Start. This is somewhat less the case in those programs that offer a home-based or combination center-/home-based option to Head Start.

The Head Start parent meetings which typically occur once or twice per month focus more often on matters related to policies and center or program operations than on parent education. This is fairly common in other Head Start programs across the country as well.

Home visit frequency is increased in four of the eleven programs when children enter Head Start. This increase is due to the fact that Head Start classroom teachers make visits in addition to those made by regular family workers. Home visits occur less frequently in four of the CFRPs; the schedule remains unchanged at the other three sites. It is common for the same family worker to continue working with the family in order to provide some form of continuity across the child's early life. In two programs, the classroom teacher rather than a family worker is assigned to maintain contact with the family; the former family worker only intervenes when a special child or family need has been identified. Other mechanisms used to provide continuity from infant-toddler to Head Start include conferences between family workers and Head Start classroom staff; sharing of records; and, in some programs, joint assessments of family and child needs, as well as development and implementation of family action plans.

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Head Start's direct intervention with children is likely to have a positive influence on the development of preschoolers. (This appears to be the case with the Las Vegas success story in Chapter 4, for example.) It is not clear, however, whether adequate emphasis is placed on parent education, especially for CFRP families who enter the program when their youngest child is of Head Start age, and who have had no involvement in the infant-toddler component of CFRP. This is not an uncommon phenomenon in CFRP; 36 percent of the families in the six impact study programs entered CFRP in this manner.* Further, at some sites at least, it is doubtful whether CFRP is fulfilling its promise to afford continuity for children and parents at the point of infant-toddler/Head Start transition.

Preschool-School Linkage Component

This component of CFRP is designed to provide continuity and ease the transition from Head Start to public school for children, their parents, and school personnel. This is the least clearly defined and well-developed of the three major CFRP components. This is partly because considerably fewer resources are allocated to PSL than to other components of the program

Some transitional services are provided as part of PSL. They often include orientation of children, their parents, and schools; trouble-shooting in response to requests from parents or school personnel; and tutoring of children either by CFRP staff or through referral to community tutorial services. Other common practices are sharing children's records with the public schools and assisting in the placement of special needs children.

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*Phase II Program Study Report, Chapter 5, February 1980.

Linkages have been established with public schools at all eleven sites. The linkage system often is limited, however to establishing contact with schools, finding out about registration procedures, and informing schools about the CFRP children that will enter. Comprehensive follow-up on all school-age children in CFRP is not feasible in most programs, partly because only a few staff are available to work with the numerous schools (and/or school districts) which CFRP children enter. Program intervention is usually limited to special problem cases that have been identified either by parents or school personnel. (An example of such intervention is included in the Oklahoma City success story in Chapter 4.)

Six programs continue to make regular home visits to PSL families once their youngest child enters school. Other programs make visits only if a particular school-related problem arises. Even if home visits occur regularly, they are less comprehensive in nature as a general rule. The rationale is that by the time a child enters public school the family is likely to have been in CFRP for several years and to require less assistance from the program.

The importance of continued parent involvement in the child's education--a process started in the infant-toddler and Head Start component--is stressed in all programs. Parents are encouraged to have regular contact with school personnel and to work with the child on problem areas or assignments that are brought home from school. More emphasis is placed on this in programs with regular PSL home visiting schedules than in sites where little or no contact is maintained with families after the child graduates from Head Start.

Most programs do not conduct any center sessions that are specifically aimed at parents of school-age children. Instead, these parents are invited to attend center sessions conducted as part of other CFRP components.

Again, the limitation on the resources allocated to the PSL component at most sites raises some doubt about CFRP's ability to provide effective continuity to children and parents at the point of entry into elementary school.

5.2 What Adaptations of Common CFRP Processes (Assessment, Goal Setting, and Planning) Are Characteristic of CFRP Models?

One of the mandates of CFRP is to individualize and tailor program services to meet specific family and child needs. In order to do so, it is necessary to assess needs, establish goals, and develop family action plans. These processes are an integral part of program operations at all eleven CFRPs. Two different approaches are being used in assessing family needs:

- In the Assessment Team Model a team of people, which may include family advocates, home visitors, supervisory and support staff, and--when appropriate--staff members from other community agencies, meet formally to review needs data which have been gathered by family workers. The assessment meeting is the basis for establishing specific family goals and determining who will take what steps, and when, to achieve those goals: the family action plan.

- In the Single Worker Model, no formal assessment meeting takes place. It is the responsibility of the family worker to complete an assessment form with the family and to develop a plan for the provision of services.

The team approach appears to be more comprehensive, in that it brings together the expertise of different people to help in addressing specific family or child needs. All except one of the eleven programs have adopted the team assessment approach.

In both models, the family action plan is the product of mutual agreement between the parents and family workers. Four programs require that parents be present at the formal assessment meeting; at other sites they are encouraged to attend. The process of prioritizing family goals usually involves joint decision-making by the parents and the family worker. One factor that is considered in assigning priorities is whether a specific goal is one the program can help meet.

Needs are reassessed periodically in all programs. One purpose of reassessment is to evaluate the family's progress--as well as the effectiveness of the program in meeting their needs. Reassessments usually lead to the development of a new family action plan, or a revision or extension of the existing plan. Almost all programs have a regular schedule for reassessment; the interval ranges from three to twelve months. In one program, reassessment is an unscheduled, ongoing process.

5.3 What Can Be Learned About the Developmental Processes of Families and How They Relate to the Developmental Processes of Children?

CFRP is a "family-oriented child development program." Support of family development is seen as important because of its implications for child development. This support may take the form of parent education (as described above, in Section 5.1); of helping to meet basic needs which might otherwise distract parents from attending to their children's development; of enhancing parents' coping skills to improve the quality of the home environment; of enhancing parents' coping skills so that they model effective coping for their children.

Improved coping skills and increased independence of outside help in meeting family needs are viewed as the ultimate objective of the family development process. This model of family development is conceptualized as comprising three stages (although these are not universal, nor is the sequence invariant):

(1) *Non-coping* with family needs and *dependence* on outside help. (Note that some of these families may not yet even have reached the point of getting outside help.)

(2) *Increased coping* and choice-making and *separation* from outside help.

(3) *Effective coping* and goal-setting and *independence* of outside help, accompanied by some ability to help others.

Where CFRP is concerned, "Coping is the ultimate goal." Thus, *support* of families in their efforts to meet their own needs and to set and achieve their own goals is in the long run more important than *intervention* to meet family needs more directly. This is exemplified by the St. Petersburg success story in Chapter 4, where the family worker provided a great deal of support to the mother for what *she* wanted to do.

The danger, of course, in any program that sets out to support family development for the ultimate purpose of enhancing child development is that program staff may lose sight of that ultimate purpose as they get caught up in the practical, everyday problems faced by client families. There is evidence to indicate that, in some cases at least, this may have happened in CFRP. That is, it appears that local CFRPs are generally doing an effective job of providing needed support to family development; whether that is being passed on in the form of child development benefits is considerably more doubtful.

5.4 What Characteristics of Families, CFRP Staff, and CFRP Activities/Services Seem to Be Associated with Outcomes or Changes in CFRP Families?

This research question cannot be addressed definitively within the context of the program study; its reference to outcomes and changes suggests that it would be more appropriately addressed in the process/treatment study. Nevertheless, program study findings do shed some light here. Local CFRPs are much more successful with some families than with others, and the differences are associated with family characteristics as well as with staff and program characteristics.

As Chapter 4, on CFRP Success Stories, clearly indicates, "success" within CFRP is not a unitary construct, and is not simply defined. For one thing, as suggested by the discussion of support for the family's own developmental path, success must at least partially be defined by (as well as for) each family. If success is to be claimed, it is the family--and not necessarily the program--that must succeed. This anomaly is reflected in the two models of family success described by CFRP staff at several sites:

- Families that are not far from success (from stage 3 of the developmental process outlined above) when they enter the program. These may simply need encouragement--or even just information about available resources. Such families can often be identified readily and quickly move on to success--to effective coping and relative independence.
- Families that are not nearly so strong at the time of entry into the program (perhaps in stage 1). These require far greater expenditures of time and energy on the part of program staff, and may move on to success after two or more years of program participation.

For these latter families, the crucial determinant of success is motivation--whether they see a need for change and are willing to invest *their* time and energy to bring about that change, specifically by way of active participation in the program. Their *expectations* for success are equally important, as are the expectations of program staff. A match between program services and family needs--and, in personal terms, between family worker and family--is also a determinant of success. More generally, CFRP staff feel that their supportiveness, the comprehensiveness of their program, and individualization of services are the three most important contributors to overall success.

5.5 What Processes Can Be Associated with Family Development in Different Types of Families? How Do Different Family Configurations Serve to Differentiate the Models in Terms of Program Operations and Services?

Different types and categories of families are viewed by CFRP staff as being differentiated by need and as requiring differential program approaches. Specifically, they discussed: single-parent families; two-parent families; families with working mothers; families with teenage mothers; and multi-problem/high risk families.

Single-Parent Families

The majority of CFRP families are headed by single women. Needs described as being peculiar to these women--or particularly problematic for them--include lowered self-esteem, a heavy burden of child-rearing responsibility, a lack of opportunities for recreation, isolation and loneliness, problems in dealing with home repairs and landlords, and financial problems. CFRP offers these women direct, need-specific assistance, but emphasizes *support*, including assurances as to status and role. Parent education sessions and home visits focus on suggestions for dealing with practical, everyday problems, including the issue of how to make time for the child. CFRP parents also interact to support one another, offering each other friendship and encouragement as well as exchanging baby-sitting and transportation services. Participation in CFRP center sessions also affords the mother at least occasional opportunities to get away from her children and spend time with adults.

Two-Parent Families

Two-parent families are served by the programs in much the same way as single-parent families are: the focus is on the mother and the children. (This focus is clearly illustrated by the success stories in Chapter 4, even though most of these are two-parent families.) Father participation tends to be minimal. This is partly because many fathers work during the day, when home visits are conducted and center sessions are held. However, experiments with evening sessions have not generally met with success: most fathers will simply not attend. By and large, the sessions are presented by and for women, and men feel awkward there. This problem is exemplified by the New Haven success story in Chapter 4; on the other hand, that story also illustrates the positive effects of a father's support--both emotional and practical--for the mother's participation in the program, remarked on by CFRP staff at a number of sites.

The lack of father participation in center sessions and home visits means that there is typically little CFRP can do in any direct way to encourage father-child interaction or to strengthen the marital relationship. In fact, it appears that in some cases a mother's involvement in CFRP may be threatening to her husband and to their relationship.

The chief exceptions to the general pattern of nonparticipation by fathers are among some Hispanic families in Las Vegas, Gering, and Modesto. In some case these fathers are very actively involved in CFRP activities. In Las Vegas, it appears that this is largely due to the efforts and the personality of the one Spanish-speaking home visitor, who organizes many special activities for and with her families.

Working Mothers

Mothers who work full-time face the same obstacles to active participation in CFRP as working fathers--specifically, schedule problems. Some efforts have been made to accommodate program schedules to mothers' working schedules, but these have been largely unsuccessful. At most sites, working mothers are not encouraged to enroll in the program, although if they start working after they have enrolled CFRP staff will attempt to serve them. Nevertheless, many families of working mothers do drop out. It is especially difficult for these families to remain enrolled after the children reach Head Start age, because at most sites Head Start is not a full-day program. In the New Haven success story, it is the father who takes the child to Head Start; he is able to do this because he works nights.

CFRP staff feel that in many cases the financial benefits of maternal employment are minimal, partly because the mother often makes just enough money to be ineligible for public assistance. (This paradox is illustrated by the Jackson success story, although in that case it was the father who was working.) Where this is the case, the CFRP may try to find nonpublic sources of support. One reason it may not "pay" to work, in the view of staff, is that day care for children is often very expensive, and sometimes hard to find. CFRP staff spend a good deal of time seeking out quality day care at affordable rates.

All working mothers seem to encounter a shortage of time. Parent education sessions focus on time management techniques, and emphasize "quality--not quantity" of time spent with children. In some cases, CFRP staff may feel that a working mother simply does not have enough time and energy to be a good parent, and may suggest that she quit work and go on welfare so she can concentrate on parenting.

Teenage Mothers

Teenage mothers are caught in a role conflict because of their dual status as adolescents, who are still growing and developing, and as mothers, who are responsible for the growth and development of a young child. They are lacking in knowledge as to that child's needs, yet have continuing special needs of their own. CFRP staff must be exceptionally sensitive to this population, helping to fill information gaps and meet needs without "taking over"--and arousing adolescent rebellion. In general, the programs do not offer separate parent education sessions for teenage mothers, preferring to expose them to opportunities for interaction with older mothers. They may offer special social activities for teens, however. The special needs of these mothers are the focus of home visits, which can be more individualized.

In many cases, teenage mothers in CFRP are living at home with their parents, and CFRP family workers must often work with the extended family in an effort to resolve intergenerational disputes. Where the mother is desirous of getting out on her own and establishing an independent household, program staff will help by providing information and support. Often they will recommend that the mother not make the move until she is better prepared to do so.

Many teenage mothers want to finish high school, and CFRP encourages this by offering counseling and tutoring, arranging day care, and also working with the schools to combat absenteeism and work with academic and behavioral problems. Unfortunately, attendance in school raises the same obstacles to active participation in CFRP as those faced by working mothers and fathers.

Multi-Problem/High-Risk Families

Like "success," "multi-problem/high-risk" is subject to a variety of definitions. However, there are a number of commonalities among the families so classified by CFRP staff: several children in the family, inadequate parenting, and behavioral problems on the part of the children; familial discord; frequent or chronic illness and substance abuse; poorly educated parents, often mildly retarded or learning-disabled; economic needs and poor money management; inadequate housing; generally poor coping skills. In some cases multi-problem/high-risk families are referred to CFRP by courts or local government agencies.

Most CFRP staff feel they are well equipped to serve these families, although in some cases the level and intensity of service required may mean that there is a danger of neglecting other families for the sake of a few especially needy ones; if this begins to happen, program staff try to get other agencies more heavily involved in the case. In general, services to multi-problem/high-risk families are not essentially different from services to other families. The specific help offered depends on the specific problem presented. Survival needs are generally dealt with first, and then personal growth. The ultimate objective for these families, as for all families, is that they learn to deal with their own needs and cope with their own situation on a continuing basis. (The St. Petersburg success story in Chapter 4 is an excellent example of a multi-problem/high-risk family.)

Families with handicapped children often need special help. At most sites, program staff receive training in dealing with the handicapped; several have access to the services of a specialist in this area, and all work closely with agencies that are able to provide specialized services to handicapped children and their families. In Salem, there is a special parent education group for parents with handicapped children. (See the Salem success story in Chapter 4.) At several sites, these parents are helped by means of counseling to deal with their own feelings about the handicap, to understand its impact on the family and--in general--to cope with the attendant problems.

5.6 What Types of Staff, Program Operations, and Service Packages Are Characteristic of CFRP Models? What Are the Commonalities and Differences in CFRP Programs in the Mix of Direct and Indirect Services They Provide?

Every CFRP provides developmental services to children (including developmental assessments at most sites) and educational services to their parents. Staff from nearly every program list counseling among the services they provide directly to parents. A number of family advocates and home visitors are trained counselors; further, several programs retain the services of mental health professionals who are made available to CFRP families. Other direct services, offered at selected sites, include health and nutrition screening and immunizations; various types of treatment, such as speech therapy or the services of a dental hygienist; day care; job counseling; legal advice; recreational opportunities; and even, at one site, translating services. In general, these services are provided directly by CFRP either because they are not available elsewhere or because their availability is in some way hampered by inadequate resources, agency attitudes, or other access problems.

On the other hand, CFRP staff differ from site to site in the degree to which they prefer to provide services directly as opposed to referring families to other, more specialized agencies to receive services. It is possible to identify two models, at the extremes on this preference scale:

- The Direct Services Model applies to programs in which staff see themselves as being primarily service-providers. This model is exemplified by the Salem CFRP, which frequently hires outside personnel to offer specialized services within the program because of a preference for direct provision.
- The Community Linkage Model applies to programs in which staff see themselves primarily as providing a connection to appropriate community resources--that is, where family needs (as opposed to child development and parent education needs) are concerned. This model is exemplified by the Las Vegas CFRP, which hires no outside people to offer specialized services within the program, but rather sends families outside to get such services.

No CFRP fits either model precisely: even Salem staff refer when necessary. Nevertheless, these models do provide a useful device for understanding a genuine difference between programs. In actuality, every CFRP probably falls somewhere between these two extremes.

When CFRP staff do refer to another agency, they frequently must take the family to that agency. Transportation systems at most CFRP sites are fraught with problems, especially for low-income families. Agencies are often comparatively inaccessible; the families typically have no cars, or old cars that are susceptible to breakdown; the communities have no public transportation, or else it is expensive, unreliable, and inconvenient. In fact, transportation is a major direct service provided by CFRP at several sites. On the other hand, at all of the programs, family workers continually try to encourage parents, progressively, to: get to agencies on their own; make their own initial contacts and appointments with agencies; find out for themselves where to get the help they need; develop the resources to help themselves.

5.7 What Community Services Exist and Are Utilized in Each of the Sites? How Do These Influence the Type of CFRP Model That Is Developed?

With few exceptions, CFRPs at all eleven sites believe that the community resources available to low-income families are adequate to meet their needs. (The exceptions include unavailability of dental and/or medical care; a lack of facilities for recreation and adult education; and a lack of psychological and mental health services.) The fact that resources are present, however, does not always mean that they are readily accessible to low-income families. The most common obstacles are lack of transportation facilities to get families to agencies, and lack of information on the part of families as to what resources are available. Improving access to community services is an important part of the CFRP mandate.

All CFRPs have established an extensive network of linkages with social service agencies in order to reduce fragmentation of community services for client families--to give them one place where they can turn for a variety of programs. The process of building a network may be simply described as one of people meeting people. In most programs, this typically has become a system of "interlocking directorates," with CFRP staff sitting on boards or committees of other agencies, agency staff sitting on CFRP and Head Start boards and committees, and both sitting on interagency councils. At some sites CFRP has played an instrumental role in setting up such councils to increase communication and cooperation among agencies.

The CFRP network of linkages is far more comprehensive than is generally the case in Head Start programs. The Head Start linkages, which at almost all sites were used as a base, were expanded or changed in scope when CFRP was initiated. At some sites, this simply meant adding one or two agencies to the existing network; at others, CFRP had to establish relationships with various community agencies and interact with agency personnel in different ways. At one site, for example, whereas Head Start had tended to assume the role of an antagonist, CFRP approached agencies more positively.

The most obvious benefits of CFRP/agency linkages are improved access to agency services. When relationships are poor, it is families that suffer. At times, the benefits of CFRP linkages go beyond the client population and have a broader impact on the community at large. CFRPs at several sites have been strong advocates for change to ensure that resources are made available to low-income families. Some examples of CFRP impact on the community are: helping to set up a community pantry for emergency aid, with resources coming from private institutions; developing a well-child clinic with the help of a number of co-sponsors; providing office space so that WIC could be established locally; identifying needs and facilitating a program established by a group of churches to provide materials and labor to help low-income families with home repairs; and establishing infant day care services in the community through CFRP's grantee agency.

In general, agency views of CFRP are very positive, as illustrated in the following comments:

- CFRP is a program that ensures that families do not "fall in the cracks" between the jurisdictions and mandates of more specialized agencies.

- This community is seriously deficient in delivery of services to the poor; without CFRP people would have nowhere to go.
- CFRP is "an ombudsman for people who don't have a voice;" it is a program that takes advantage of available resources in the community and in turn makes them available to families.
- CFRP "works just as effectively as you could possibly imagine," given its funding.

The last remark is by far the most common response of agency personnel to a question as to how CFRP might be improved: Increase its funding and its coverage; have more slots available for families that are referred to CFRP by community agencies, especially those in crisis situations or who have special needs.

All of the programs appear to be doing an effective job of making sure that families receive the services they need, although the degree of effectiveness varies from site to site. At all sites, CFRP is demonstrating that linkage networks with other community service agencies can be established and that access to services can be improved. This aspect of the program is a model of interagency cooperation which could well be replicated in other communities.

5.8 Conclusions

The results of the CFRP program study to date can be summarized within the context of the four major CFRP objectives:

1. Are programs and services individualized and tailored to meet the child development-related needs of different children and their families?

TO SOME EXTENT; while services are individualized to meet specific family needs in all eleven programs, there is some question whether adequate emphasis is being placed on child development-related needs, particularly those of infants and toddlers. CFRP appears to be more concerned with family coping skills than with enhancing the development of children.

2. Are resources in the community linked so that families may choose from a variety of programs and services while relating to a single resource center--the CFRP--for all young children in the family?

YES; all CFRPs have established an extensive network of linkages with social service agencies in order to reduce fragmentation of community services for families enrolled in the program. They have given families one place where they can turn for help from a variety of programs. CFRP has demonstrated that effective linkage networks with other community service agencies can be established, resulting in increased access to services.

3. Does CFRP provide continuity of resources that will help each family to guide the development of its children from the prenatal period through the early years in school (age eight)?

TO SOME EXTENT; while there is continuity of resources available to parents, it is not clear to what extent they are aimed at helping families to guide the development of their children. This is based on the following factors:

(a) The approaches used to parent education, levels of participation in center sessions and home visits, and the focus of home visits and sessions for children provided as part of the infant-toddler component raise some questions about the effectiveness of CFRP in enhancing the development of children.

(b) At some sites, it is doubtful whether CFRP is fulfilling its promise to afford continuity for children and parents at the point of infant-toddler/Head Start transition.

(c) The limitation on resources allocated to the PSL component at most sites raises some doubt about CFRP's ability to provide effective continuity to children and parents at the point of entry into elementary school.

4. Does CFRP enhance and build upon the strengths of the individual family as a child-rearing system, with distinct values, culture, and aspirations? Does CFRP attempt to reinforce these strengths, treating each individual as a whole and the family as a unit?

YES; the success stories presented in Chapter 4 provide convincing evidence that CFRP builds upon individual family strengths and tailors the program and services to meet family and child needs. Program services and activities are dictated to a large extent by the needs and goals that individual families identify or set for themselves. It is up to parents to decide what they want out of the program. However, while individualization of program services is an explicit mandate of CFRP, it is not clear that it is maximally conducive to attaining the child development-related objectives of the program. Furthermore, there is evidence to suggest that program emphasis is not always on the "family unit," but rather that mothers are the focus of program activities. In most instances, the program does not appear to be very effective in working with two-parent families or with mothers who are employed.

CFRP, as implemented at the eleven sites, can perhaps best be described as a "family support" program rather than as a program that has child development as its major goal. The evidence obtained thus far suggests that

CFRP is effective in providing family support and linking families to community service agencies. In fact, this aspect of CFRP appears to be unique. The program could be strengthened considerably, however, by increasing program emphasis on the parent as the primary educator of her own children and on child development-related concerns.

The issues addressed in this report and other related ones will be explored in greater depth beginning in fall 1980, in the ethnographic study. This component of the evaluation will examine CFRP relationships with, and provision of services to, selected families and children, in an attempt to gain a better understanding of CFRP as a family-oriented child development program.